Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of VA Medical Center Spokane, Washington

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VA Office of Inspector General

Combined Assessment Program Reviews

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- Healthcare Inspectors review selected patient care administration and quality management activities to evaluate whether they have created an environment that supports quality patient care and performance improvement.

- 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.

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Combined Assessment Program Review of VA Medical Center Spokane, Washington

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Spokane, Washington. The review was conducted from August 21 through August 25, 2000. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care administration, quality management (QM), and financial and administrative management controls. During the review we also provided Fraud and Integrity Awareness training for about 150 VAMC employees.

VAMC Spokane is a 66-bed facility, providing medical, surgical, psychiatric, and nursing home care. The VAMC's Fiscal Year (FY) 2000 budget was $49.5 million, and staffing was 511.5 full-time equivalent employees (FTEE). In FY 1999, the VAMC provided care to 15,851 patients and reported 132,849 outpatient visits.

Patient Care Administration and Quality Management. VAMC managers had created an environment that supported quality patient care and performance improvement. The VAMC had a comprehensive QM program that provided strong oversight of the quality of care. To improve patient care administration, the VAMC needed to strengthen oversight of contract nursing homes and address several issues pertaining to staffing, pharmacy operations, and waiting times for clinic appointments. To improve QM, the VAMC needed to address issues pertaining to strategic planning, evaluations of medication usage, and the Monthly Operating Report.

Financial and Administrative Management Controls. The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, the VAMC needed to strengthen controlled substances inspections, renegotiate and effectively monitor the ambulance contract, reduce excess supply inventories, and revise information technology security contingency plans.

Medical Center Director Comments. The VAMC Director concurred with the CAP review findings and provided acceptable plans to take corrective action. (See Appendix II for the full text of the Director's comments.) We consider all 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 Medical Center Spokane

VAMC Spokane is an affiliated facility providing medical, surgical, psychiatric, and nursing home care services. Outpatient care is provided at the VAMC and at nine surrounding community locations through the use of a mobile clinic. The VAMC is one of six medical centers in Veterans Integrated Service Network 20. The VAMC's primary service area includes Spokane and 20 adjacent counties in eastern Washington, northern Idaho, and northwestern Montana. The veteran population in the service area is about 98,800.

Programs. The VAMC has 32 acute care beds and 34 nursing home beds and operates several specialty medical programs such as urology and orthopedics. Patients needing tertiary care are referred or transferred to the VA Puget Sound Health Care System in Seattle, Washington, or to VAMC Portland, Oregon. The VAMC also provides various diagnostic services to the Indian Health Service, the Idaho State Nursing Home, and Fairchild Air Force Base.

Affiliation. The VAMC is affiliated with the University of Washington School of Medicine Programs in Family Practice and Internal Medicine and provides student training opportunities in nursing, dentistry, and several other allied health programs.

Resources. In FY 1999, the VAMC's medical care expenditures totaled about $45 million. The FY 2000 budget was about $49.5 million, 10 percent more than FY 1999 expenditures. FY 2000 staffing totaled 511.5 FTEE, including 21.6 physician FTEE and 150.3 nursing FTEE.

Workload. In FY 1999, the VAMC treated 15,851 unique patients, a 5.4 percent increase from FY 1998. Inpatient care was provided to 1,930 unique patients, and the average daily census, including nursing home patients, was 50.2. The outpatient care workload was 132,849 visits.

Objectives and Scope of CAP Review

The purposes of the CAP review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to VAMC employees.

Patient Care Administration and Quality Management Review. We reviewed selected clinical activities to evaluate the effectiveness of patient care administration and quality management. Patient care administration is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and measures to ensure staff competence. QM 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 care. QM includes risk management, utilization management, total quality improvement, and coordination of external review activities.

To meet the review objectives, we inspected patient care areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. As part of the review, we used questionnaires and interviews to survey employee and patient opinions about quality of

care, timeliness of service, and satisfaction with care. The review covered the following 10 clinical operations and monitoring functions:

- Acute Medical-Surgical Unit
- Behavioral Health Care
- Nursing Home Care Unit
- Risk Management/Patient Safety
- External Oversight
- Primary Care Clinics
- Pharmacy
- Utilization Management
- Infection Control
- Compliance/Medical Information

Financial and Administrative Management Review. We reviewed selected financial and administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, prevent and detect errors and fraud, and 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 15 activities and management controls:

- Accounts Receivable
- Unliquidated Obligations
- Agent Cashier Operations
- Construction Planning
- Controlled Substances Inspections
- Pharmacy Security
- Service Contracts
- Supply Inventory Management
- Information Technology Security
- Equipment Accountability
- Equipment Acquisition
- Medical Care Cost Fund
- Nursing Home Care Contracts
- Printing Practices
- Purchase Card Program

Fraud and Integrity Awareness Training. We presented six Fraud and Integrity Awareness briefings for VAMC employees. About 150 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.

Scope of Review. The CAP review covered VAMC operations for FY 1999 and FY 2000 through August 2000. The review was done in accordance with the OIG standard operating procedures for CAP reviews.

Results and Recommendations

Patient Care Administration and Quality Management

Patient Care Administration Was Generally Effective and the QM Program Was Comprehensive

VAMC managers had created an environment that supported quality patient care and performance improvement. The VAMC had a comprehensive QM program that provided effective oversight of the quality of patient care using national and local performance measures, risk management, utilization management, infection control, and extensive data tracking. During the annual strategic planning process, VAMC managers selected 10 topics needing improvement and assigned these topics to key employees to develop and implement improvement plans. These 10 topics included pain management, timeliness of specialty care referral, management of walk-in patients, and medical treatment error reporting. We were impressed with the VAMC's strategic planning process because of its inclusiveness and the relevance of the topics chosen for improvement. Performance improvement methods were used in several services, and the chiefs of these services made periodic presentations on their issues to the Clinical Executive Board.

In July 1998, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performed its most recent triennial VAMC accreditation survey. JCAHO surveyors awarded accreditation with commendation. We were impressed that VAMC managers had implemented a program called "Once Prepared Always Ready" that involved spontaneously asking employees questions relevant to JCAHO standards and providing small rewards for correct answers.

Ongoing quality of care monitors included patient safety/risk management, infection control, restraint use, operative/invasive procedures, blood products use, and medical record documentation. We reviewed one administrative board of investigation, two tort claim reviews, and a sample of focused reviews conducted over the past 12 months. We found these review processes to be generally sound and the conclusions and corrective actions to be relevant.

As illustrated by the following examples, most of the patient care programs reviewed were operating satisfactorily.

The Homeless Veteran Program Provided a Needed Resource and Was Successful. The VAMC operated a homeless veteran program in a downtown Spokane storefront office. This program was well integrated with local, county, and state homeless services. The program managers had contracted for a wide range of services including detoxification, temporary housing, and residential treatment. During the past year, managers added a substance abuse counselor to provide on-site evaluation, referral, and counseling. In FY 1999, the program provided services to 306 veterans. In addition, the program had used donations to provide homeless veterans with comfort items such as clothing, blankets, and winter coats.

Nursing Home Care Unit Environment and Low Restraint Use Were Exemplary. We found the VAMC Nursing Home Care Unit environment to be modern, well maintained, and pleasant

for the patients. The combination of rehabilitation, hospice, and respite care seemed to be very successful. Restraint use data showed that clinicians had rarely used restraints during the past 12 months.

Opportunities for Improving Patient Care Administration

Contract Nursing Home Care -- Oversight of Care Needs Improvement

To ensure that veteran-patients receive appropriate care at contract community nursing homes, Veterans Health Administration (VHA) policy requires that VAMC employees inspect the homes each year and perform monthly visits to VA patients in the homes. An interdisciplinary team of employees should perform these inspections and visits with the objective of evaluating patient care practices and monitoring systems. The VAMC had contracts with 17 community nursing homes. Our review found that VAMC employees had completed the required annual inspections but they had not performed the monthly visits. In addition, VAMC managers did not have a process for following up on deficiencies found during the annual inspections. VAMC managers acknowledged that the review process needed improvement and told us that a Special Action Group had been chartered by the Strategic Planning Group to address these issues.

Conclusion. The VAMC Director needed to ensure that monthly visits to patients in contract nursing homes were performed and that nursing home inspection procedures included follow-up on the correction of deficiencies. The Director agreed and reported that in September 2000 the contract nursing home care program coordinator had been assigned the responsibility of ensuring that monthly visits are done. The VAMC had also revised its procedures to require follow-up on the correction of inspection deficiencies. The corrective actions are acceptable and we consider the issue resolved.

Staffing, Pharmacy, and Clinic Appointment Scheduling -- Various Issues and Concerns Should Be Addressed

During our review we noted several issues that collectively warranted management attention. Managers agreed to evaluate these issues and to take corrective actions as necessary.

Staffing Issues Raised by Employees. Several managers and employees believed that there was a need for more staff at the VAMC. Only 45 percent of the employees who responded to our survey agreed that there was sufficient staff to provide adequate care to all patients who needed it. Many employees in direct patient care positions indicated that they felt overwhelmed by their workloads. More significantly, they believed that their ability to attend to patient needs was, at times, inadequate. VAMC managers acknowledged that patient workload in ambulatory care had increased to the point that additional employees were needed. Managers had plans to recruit and hire additional employees.

Pharmacy Service. Patients complained of long waiting times to obtain prescriptions at the Pharmacy. Pharmacy managers believed that this problem was attributable to a shortage of pharmacy staff. Managers told us that they had been able to reduce the average waiting time from more than an hour to about 45 minutes. Several nurses complained that Pharmacy services

were not available after 6:00 p.m. and that the backup system was inadequate. In addition, because of the staffing shortage Pharmacy managers were not able to review adverse drug reactions (ADRs) and had not performed any medication usage evaluations (MUEs). Both ADR reviews and MUEs are necessary for efficient and effective operations. To improve waiting times and extend service hours, managers had developed plans to recruit additional personnel. The additional personnel will also allow Pharmacy to perform ADR reviews and MUEs.

Waiting Times for Scheduling Clinic Appointments. VAMC managers needed to reduce the time that patients had to wait to obtain appointments for some clinics. VHA has established an appointment waiting time performance goal of 45 days or less for six specified clinics. As of July 2000, the VAMC had not met the 45-day goal for four of the six clinics -- Primary Care (52.1 days), Orthopedics (58.6 days), Urology (104.9 days), and Eye Care (190.2 days). Long clinic appointment waiting times also contributed to an increased number of walk-in patients. VAMC managers had chartered a Special Action Group to evaluate and improve appointment waiting times and the management of walk-in patients.

Patient and Employee Survey Results. As part of the CAP review we obtained perceptions from employees and patients through the use of questionnaires and interviews. The employee questionnaire covered topics such as job satisfaction, staffing, and quality of care. The patient questionnaire covered topics such as treatment timeliness and employee courtesy. A total of 136 employees and 137 patients completed questionnaires. The overall results of the surveys were very positive. The specific results listed below may be of interest to managers in their ongoing efforts to improve customer service and employee morale. (We sent the full survey data report to VAMC management.)

- VHA policy requires one physician to be in charge of each inpatient's care. Only 74 percent of the inpatients surveyed responded that one physician was in charge of their care.

- Only 33 percent of the inpatients interviewed felt that nursing employees answered call lights within 5 minutes. However, 64 percent of the inpatients who had experienced significant pain felt that they received adequate medication or treatment to relieve the pain.

- Ninety-one percent of patients surveyed rated the quality of care as excellent, very good, or good, and 85 percent would recommend the VAMC to an eligible friend or family member.

- Ninety-three percent of the employees rated the VAMC's quality of care as excellent, very good, or good, and 87 percent would recommend the VAMC to an eligible friend or family member.

- Employees expressed dissatisfaction with the recognition and awards process. Only 45 percent of surveyed employees perceived that recognition and awards reflected performance.

- Employees were comfortable in reporting their own errors (87 percent) and slightly less comfortable in reporting their colleagues' errors (71 percent). Seventy-three percent of employees surveyed perceived that constructive actions were taken when errors were reported.

Conclusion. The VAMC Director needed to ensure that the issues discussed above were reviewed and that corrective actions were taken as warranted. The Director agreed and reported that the corrective action on several issues had begun or had been completed. To help address the staffing issues raised by employees, Patient Care Services had hired additional nurses, and VAMC managers had adjusted FY 2001 budgets where needed to help meet workload demands. To improve pharmacy operations, additional staff had been hired, recruitment for a Chief of Pharmacy Service was underway, prescription refills were being done by mail, and there were plans to install a robot system for filling prescriptions. To reduce waiting times for scheduling appointments, the VAMC had begun several actions, including refining the team approach model used in primary care and hiring a primary care physician, a physician assistant, and an optometrist. The corrective actions are acceptable and we consider the issues resolved.

Opportunities for Improving the QM Program

Strategic Planning, Medication Usage Evaluations, and Monthly Operating Report -- Various Issues and Concerns Should Be Addressed

We noted several QM issues that collectively warranted management attention. Managers agreed to evaluate these issues and to take corrective action as necessary.

Strategic Planning. While the strategic planning initiative was positive, the process that managers used to select topics for improvement could be enhanced through the use of criteria-based prioritization. Managers commit significant resources to performance improvement and should give thoughtful consideration to the choices of topics. Criteria that other VAMCs have successfully used to select performance improvement topics include potential for improving patient satisfaction, decreasing costs, and improving efficiency.

Medication Usage Evaluations. We noted that the VAMC did not have a systematic process for evaluating medication usage and suggested that the Pharmacy and Therapeutics (P&T) Committee develop a meaningful review process for this high-volume, high-cost, high-risk area. For example, some VAMCs systematically review selected antibiotics for appropriateness of use given the emergence of resistant strains.

Monthly Operating Report. Managers did not always adequately emphasize the implementation of recommendations from focused reviews and special action groups and did not always track these recommendations to resolution. To increase the awareness of these recommendations, we suggested that the QM Coordinator include significant recommendations on the Monthly Operating Report (MOR) until resolved. We also suggested that managers could make the MOR easier to understand and use by including the goal for each data element. For example, waiting time data for filling pharmacy prescriptions are provided on the MOR, but not the waiting time goal of 30 minutes. Because the MOR is so voluminous, it is difficult for managers to remember all the goals.

Conclusion. The VAMC Director needed to ensure that: (a) managers used criteria-based prioritization to select topics for improvement efforts; (b) the P&T Committee developed a meaningful medication usage evaluation process; and (c) the MOR included recommendations

from focused reviews and special action groups and goals for each data element. The Director agreed and reported that the corrective action on several issues had begun or had been completed. For example, as of November 2000 criteria-based prioritization had been incorporated into the planning process, the P&T Committee had begun reporting on ADRs and monitoring MUEs, and targets for each data element had been added to the MOR. The corrective actions are acceptable and we consider the issues resolved.

Financial and Administrative Management

Management Controls Were Generally Effective

VAMC management had established a positive internal control environment, the financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. As illustrated by the following examples, we found no significant deficiencies in several of the activities reviewed.

Accounts Receivable Were Reconciled Monthly and Aggressively Pursued. Fiscal Service had effective controls for identifying and pursuing delinquent vendor and employee receivables. We reviewed accounts receivable records for the 7-month period January through July 2000 and found that Fiscal Service staff had reviewed the accuracy of billed, collected, and delinquent receivables by reconciling the General Ledger to subsidiary accounting records. We also reviewed Fiscal Service collection efforts for 10 high dollar value receivables older than 90 days and found no deficiencies. Receivables with recovery potential were aggressively pursued through the use of collection letters and telephone calls, and receivables that did not have recovery potential were promptly written off as uncollectible.

Unliquidated Obligations Were Reviewed Monthly and Cancelled When Not Needed. As of July 31, 2000, the VAMC had 862 unliquidated obligations valued at $5.4 million. To determine if Fiscal Service reviewed obligations each month and cancelled delinquent obligations when appropriate, we reviewed a judgment sample of 20 obligations (10 undelivered orders valued at $326,910 and 10 accrued services payable valued at $258,768). We found that Fiscal Service was reviewing unliquidated obligations every month, contacting VAMC services to determine whether the obligations were still needed, and promptly canceling obligations that were no longer needed.

Agent Cashier Operations Were Sound. Our review of agent cashier operations found no deficiencies. We requested and observed an unannounced audit of the agent cashier. VAMC staff conducted the audit properly. The audit found no overages or shortages in the agent cashier's funds. We analyzed recent cash disbursements and concluded that the amount of the cash advance was appropriate. The combinations to the agent cashier's and the alternate cashiers' safes had been properly secured. Agent cashier unannounced audits were generally performed every 90 days as required.

Construction Projects Were Properly Planned. As of August 2000, the VAMC had begun or planned to begin 32 construction projects (estimated cost = $10.4 million). We selected a judgment sample of five high cost projects (estimated cost = $3.0 million), reviewed the justifications for these projects, and inspected the areas affected by the planned construction. We concluded that all five projects were well planned, had been properly justified, and were needed to correct significant functional deficiencies. The VAMC planned two minor construction projects to renovate the Medical/Surgical Ward and the Acute Care Unit (estimated cost = $2.6 million). The remaining 30 projects were nonrecurring maintenance projects to replace sections

of the hospital roof, paint the hospital exterior, and correct various safety and functional deficiencies (estimated cost = $7.8 million).

Opportunities for Improving Management Controls

Controlled Substances Inspections -- Accountability Procedures Should Be Strengthened

We reviewed the VAMC's controlled substances inspection procedures to determine if they ensured that controlled substances were properly accounted for. VAMCs are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The inspectors must be VA employees who are not pharmacists, physicians, nurses, or supply personnel. Inspectors should physically count the quantities of controlled substances on hand and reconcile these quantities to perpetual inventory records. We requested and observed an unannounced inspection of selected areas where controlled substances were stored and dispensed. We also reviewed records of the inspections done for the 14-month period July 1999 through August 2000. Our review found four inspection deficiencies that needed improvement.

First, inspection procedures did not cover excess, returned, or unusable controlled substances stored in the pharmacy vaults. VHA policy requires that inspections include these drugs. To ensure independent oversight of stored controlled substances and to comply with VHA policy, these drugs should be included on perpetual inventory records and counted during every inspection. Our observation of the VAMC inspection process noted the following deficiencies that illustrate the importance of counting all controlled substances during inspections:

- In the pharmacy vault we found three packages containing a total of 80 doses of oxycodone liquid and a returned mail-out prescription envelope containing 50 tablets of oxycodone with acetaminophen that were not on the perpetual inventory records and not counted during the inspection. The Chief of Pharmacy Service determined that 40 of the 80 doses of oxycodone liquid had been dispensed to a patient who had subsequently returned the drugs in May 2000. These 40 returned doses had not been counted during the three previous inspections. The Chief of Pharmacy Service could not account for the other 40 doses. We determined that the 50 oxycodone tablets in the mail-out prescription envelope had been returned to the pharmacy 6 days before the inspection. The inspector did not count any of these drugs because they had not been listed on the perpetual inventory records. To eliminate the potential for undetected diversion, these drugs should have been posted to the inventory records immediately after they were placed in the vault, and the inspector should have counted the drugs during the inspection.

- The inspector did not review drug expiration dates during his inspection of the pharmacy vault. The inventory records for the vault showed that 27 different drugs stocked in the vault had expired. However, the inventory records were incorrect for 26 of the 27 drugs and, in fact, the stock had not expired. The other item had expired 2 months before the inspection but was still on the shelf for dispensing. When we showed the expired drug to the Chief of Pharmacy Service, he removed it from the shelf and told us that it would

be destroyed. He agreed that inspectors should review expiration dates during their inspections so that errors in the inventory records could be identified and corrected.

The second deficiency was that the inspection procedures did not account for all Controlled Substance Administration Records, commonly called green sheets. Green sheets are maintained in clinics and wards where controlled substances are stored and show a running balance of the quantity on hand for each controlled substance stocked. As we observed the inspection of three wards, we noted that the inspector's "Log For Controlled Substances" showed that 194 green sheets had been issued to the three wards. However, the inspector could find only 102 green sheets. According to the Chief of Pharmacy Service, the remaining 92 green sheets had been returned to Pharmacy Service because the quantities of controlled substances recorded on the green sheets had been reduced to zero. However, the "Log For Controlled Substances" had not been updated. In addition, we reviewed inspection records for the 10-month period November 1999 through August 2000 and found that on all 10 inspections missing green sheets had not been accounted for. To properly account for all the controlled substances stocked in clinics and wards, the number of green sheets listed on the inventory records should match the number of green sheets maintained in the clinics and wards. Missing or unaccounted for green sheets could be used as a tactic for concealing drug diversions.

The third deficiency was that during the inspection a pharmacist performed the physical counts of the controlled substances in the pharmacy vault and nurses performed the counts of the controlled substances on the hospital wards. VHA policy requires that the inspector perform the physical counts.

The fourth deficiency was that the VAMC listing of controlled substances inspectors showed that one of the inspectors was a nurse. VHA policy specifies that nurses should not be inspectors.

In addition to the inspection deficiencies discussed above, we noted two physical security issues that needed to be addressed. First, during the inspection we observed a controlled substance delivery to the pharmacy. Two employees counted these controlled substances and then left them unattended outside the vault. Second, we noticed several instances when the vault door was left open. To improve physical security, controlled substances should be placed in the vault immediately after delivery and the vault door should be kept closed at all times.

Conclusion. The VAMC Director needed to ensure that: (a) excess, returned, and unusable controlled substances were promptly posted to perpetual inventory records and counted during inspections; (b) inventory records accurately reflected the expiration status of all controlled substances; (c) inventory records were promptly updated when green sheets were removed from clinics and wards; (d) inspectors performed physical counts of all controlled substances; (e) inspectors were not pharmacists, physicians, nurses, or supply personnel; and (f) controlled substances delivered to the VAMC were immediately placed in the pharmacy vault and the vault door was kept closed at all times.

The Director agreed and reported that in October 2000 the VAMC had revised its controlled substances inspection policies and procedures to cover excess, returned, and unusable drugs, to require pharmacy technicians to update drug lot numbers and expiration dates as new shipments are received, and to require the reconciliation of inventory records with green sheets. The

Director also reported that the nurse had been removed from the list of inspectors, that pharmacy employees had been instructed to secure all drugs in the vault during the receiving process, and that the vault door was now being kept closed at all times. In December 2000, the VAMC's procedures will be revised to require inspectors to perform physical counts during inspections. The corrective actions are acceptable and we consider the issue resolved.

Service Contracts -- The Ambulance Contract Should Be Renegotiated and Effectively Monitored

We reviewed the VAMC's service contracts to determine if the contracted services were needed, reasonably priced, and effectively monitored. As of July 2000, the VAMC had 19 service contracts with a total value of $1.9 million. We reviewed the records pertaining to five contracts with a total value of $500,000 and interviewed responsible contracting officers and contracting officer technical representatives. We also reviewed contract monitoring procedures to determine if they ensured that the VAMC actually received the services billed by the contractors and that VAMC payments were correct.

All five of the contracts had been solicited through the Commerce Business Daily and awarded based on competitive bids. For four of the five contracts, the services were needed, prices were reasonable, and contractor performance was effectively monitored. However, for the fifth contract, which covered ground ambulance services, improvement was needed in both the negotiation of the contract and the monitoring of contractor performance. The cost of this contract significantly exceeded original contract estimates, and monitoring procedures did not ensure that the VAMC would not erroneously pay for unauthorized trips or for duplicate billings.

Contract Costs Underestimated. The ambulance contract estimated that the cost of services for FY 2000 would be $88,443. However, as of July 2000, contract costs had already reached $203,730. Based on the contractor's bills that had been processed through July, the total cost of the contract for the fiscal year would be about $306,600, which is more than three times the originally estimated cost ($203,730 for 8 months of bills processed through July = $25,466 per month x 12 months = $305,592). We concluded that contract costs were higher than anticipated because Health Administration Service (HAS) and contracting staff had underestimated both the total number of ambulance trips that would be needed and the number of higher cost trips outside the Spokane city limits.

The contract estimated that a total of 434 trips would be needed. The contract rates were $177 for trips within the city limits and $177 plus $10.25 per mile for trips outside the city limits. The contract estimated that trips outside the city limits would total 700 miles. Our review of the contractor's bills for the month of July 2000 found that 74 authorized ambulance trips had been made in this single month. This indicated that for the entire fiscal year about 888 trips would likely be needed (74 trips x 12 months), 454 more trips than the 434 estimated. In addition, eight of the July trips were outside the city limits, and these eight trips involved far more mileage than the 700 miles estimated for the entire year. (There were six trips to the VA Puget Sound Health Care System in Seattle and two to VAMC Portland, for a total of 2,364 miles.)

Our review of the contractor's bills identified a potential opportunity for reducing the cost of trips outside the city limits. For trips to Seattle the contractor had charged a flat rate that was less than the per mile rate specified by the contract. Under the terms of the contract, a trip to Seattle should have cost $3,026.50 ($177 rate + $2,849.50 for mileage). However, the contractor had charged a flat rate of $2,500, which was $526.50 less than the contract cost. This suggested that the contractor may be open to negotiating flat rates for longer trips, not only to Seattle but to other destinations as well.

The contract estimate of required ambulance services was understated because VAMC staff had not adequately analyzed historical ambulance workload or attempted to negotiate flat rates for trips outside the city limits. HAS management agreed that a thorough analysis of ambulance service workload data would allow the VAMC to negotiate from a stronger position based on the higher volume of services needed. Management also agreed that efforts should be made to negotiate flat rates for longer trips based on the fact that the contractor had shown a willingness to accept lower rates for trips to Seattle.

Contract Monitoring Inadequate. HAS staff responsible for monitoring performance on the ambulance contract did not have adequate controls to ensure that the VAMC did not inadvertently pay for unauthorized trips or for duplicate billings. Although we did not find any instances of this occurring, it was apparent that controls were not adequate to prevent such erroneous payments. HAS staff did not prepare written authorizations for all ambulance trips and did not properly reconcile contractor bills to ensure that charges were correct.

VA policy requires ambulance services to be authorized in writing before services are provided. HAS staff could not provide us with written authorizations for 8 of the 46 bills for ambulance trips made during July 2000. In addition to preparing the written authorizations, HAS staff should record the estimated costs of individual ambulance trips on VA Form 4-1358 (Estimated Miscellaneous Obligation or Change in Obligation) when the trips are authorized. When contractor bills are received, HAS staff should then reconcile the number and the estimated costs of trips shown on the Form 4-1358 with the contractor's bill. Instead of following this procedure, HAS staff waited until the bills were received and then used the costs shown on the bills to retrospectively complete the Forms 4-1358. This process defeated the purpose of the reconciliation, which is to ensure that payments are correct.

Conclusion. The VAMC Director needed to ensure that: (a) a new ambulance contract was negotiated that accurately estimated service requirements; (b) contracting staff attempted to negotiate cost-effective flat rates for trips outside the Spokane city limits; (c) all ambulance trips were properly authorized in writing; and (d) responsible HAS staff received training on properly preparing VA Forms 4-1358 and on reconciling the forms with contractor bills. The Director agreed and reported that as of November 2000 the ambulance contract had been modified to reflect actual usage and to include flat rates for trips to Seattle and Portland, trips were being properly authorized, and HAS staff had received the suggested training. The corrective actions are acceptable and we consider the issue resolved.

Supply Inventory Management -- Excess Inventories Should Be Reduced and Controls Enhanced

We evaluated VAMC management of medical, prosthetic, engineering, and pharmaceutical supply inventories to determine if controls were adequate to prevent the build-up of excess inventory. We concluded that the VAMC needed to reduce excess inventories of all four types of supplies and that automated inventory controls were needed to help manage engineering and pharmaceutical supply inventories.

In FY 1999, VAMC Spokane spent $6.1 million on medical, prosthetic, engineering, and pharmaceutical supplies. VAMCs should maintain inventory levels that meet current operating needs. Inventories above those levels should be avoided so that funds are not tied up in excess inventory. Generally, current needs can be met with inventories of no more than a 30-day supply. For pharmaceutical supplies, current needs can be met with a 10-day supply because the prime vendor can usually deliver pharmaceuticals within 1 day of ordering. To adequately monitor supply inventory levels VAMCs must effectively use VA's automated inventory management system, the Generic Inventory Package (GIP). With inventories of thousands of items in multiple storage locations and with frequent deliveries to and distributions from any or all storage locations, automation is the only effective way to track receipts, quantities on hand, demand, and distribution. The review results for the four types of supplies are discussed below.

Medical Supplies. VAMC Spokane was one of the first VAMCs to use GIP to manage medical supply inventories and has been recognized by VHA as a benchmark of effective inventory management. Acquisition, Nutrition, and Materiel Management Service (AN&MMS) had effectively used GIP to reduce the medical supply inventory value from $164,472 at the end of FY 1998 to $98,521 as of August 2000 (a 40.1 percent reduction). Most of the VAMC's medical supply inventory was stocked in an on-site warehouse while the Supply, Processing, and Distribution Section of AN&MMS maintained a minimal inventory of 1 to 3 days of supply.

AN&MMS was using good inventory management practices, such as performing physical inventories and ordering supplies frequently. However, for many items stored in the warehouse, AN&MMS had set normal stock levels in GIP too high or had purchased quantities of supplies that exceeded normal stock levels. As a result, despite inventory reductions over the last several years, medical supply inventories still exceeded a 30-day supply. To test the reasonableness of the warehouse inventory levels we reviewed a sample of 10 high-cost supply items. Nine of the items had stock on hand that exceeded a 30-day supply, with the average for all nine items being 179 days. The warehouse inventory of medical supplies consisted of 807 items valued at $98,521 million. By analyzing GIP data and the results of our sample review, we estimated that the value of medical supply inventory exceeding current needs was $41,017 (41.6 percent of the total value). AN&MMS managers agreed that warehouse inventories for most items could be reduced to less than a 30-day supply.

Prosthetic Supplies. In April 2000, AN&MMS began using GIP to control prosthetic supply inventories and also began using the same inventory practices used to manage medical supplies. Most of the VAMC's prosthetic supply inventory was stocked in an on-site warehouse while Prosthetic Service maintained a minimal inventory. To test the reasonableness of warehouse

prosthetic inventory levels we reviewed a sample of 10 high-cost items. All 10 items had stock on hand that exceeded a 30-day supply, with the inventory levels ranging from 44 days to 10 years of supply. AN&MMS maintained a prosthetic supply inventory of 89 items valued at $24,000. Based on GIP data and our sample review, we estimated that the value of the prosthetic supply inventory exceeding current needs was $20,400 (85 percent of the total inventory value).

Engineering Supplies. Engineering and Technology Service (ETS) did not use an automated inventory system and did not have any other inventory records to manage engineering supply inventories. The absence of an inventory system prevented ETS from using basic inventory controls such as establishing normal stock levels, analyzing usage patterns to determine optimum order quantities, and conducting periodic physical inventories. Instead, supply managers had to rely on their experience and on informal estimates of usage to determine when and how much to order. The absence of written inventory records and normal stock level standards caused supply managers to purchase engineering supplies that exceeded current needs. We reviewed the quantities on hand and asked ETS engineers to estimate the usage rates for a judgment sample of 10 engineering supply items. For 8 of the 10 items the stock on hand exceeded the 30-day standard, with inventory levels ranging from 70 days to 17 years of supply. Because ETS did not maintain inventory records, we could not estimate the value of engineering supply inventories or the amount of inventory that exceeded current needs.

Pharmaceutical Supplies. Pharmaceutical inventory levels were significantly lower than inventories of other types of supplies because of the efficiency of the prime vendor's supply order system and next-day delivery service. Although Pharmacy Service did not use an automated inventory control system to manage pharmaceutical inventories, supply managers were using some good non-automated inventory management practices, such as manually establishing normal stock levels and monitoring and ordering supplies daily. However, written inventory records and usage data were not available, and supply managers had to rely on experience and judgmental estimates of usage to determine when and how much to order. Our review of 10 sample items found that inventory levels for 5 items were below the 10-day standard and that levels for the other 5 items were between 11 and 26 days. Because Pharmacy Service did not maintain inventory records, we could not estimate the value of pharmaceutical inventories or the amount of inventory that exceeded current needs.

Conclusion. The VAMC Director needed to ensure that automated inventory controls were effectively used to reduce supply inventories to levels consistent with current needs. The Director agreed and reported that as of October 2000 actions to improve inventory management were in progress. AN&MM and Prosthetics Services would review procedures for setting stock levels and would reduce stock to levels consistent with current needs. ETS would include selected engineering supply items in GIP. Pharmacy Service would use GIP for replenishing supplies and would use VHA's Drug Accountability software to automate pharmacy inventory management. The target date for completing all corrective actions is March 1, 2001. The corrective actions are acceptable and we consider the issue resolved.

Information Technology Security -- Contingency Plans Should Be Revised

We reviewed the VAMC's information technology security to determine if controls were adequate to protect Automated Information System (AIS) resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that the physical security for computer rooms and equipment was adequate, that on-site generators provided adequate emergency power for local area network computers, and that controls were in place to force users to change their passwords every 90 days and to lock out users after three failed password attempts. However, our review also found that AIS security could be enhanced and brought into full compliance with VA policy by preparing a more detailed contingency plan.

VHA facilities are required to develop and implement AIS contingency and recovery plans. The plans should be designed to reduce the impact of disruptions in services, to provide critical interim processing support, and to resume normal operations as soon as possible. Plans should be sufficiently detailed so that their success does not depend on the knowledge or expertise of one or two employees. The VAMC contingency plan could be improved by prioritizing mission critical systems, identifying support resources, designating an alternative processing site, and establishing off-site storage for critical backup files.

Critical Systems Prioritization. The VAMC contingency plan did not prioritize the major AIS systems. The only system listed in the plan was the Veterans Health Information Systems and Technology Architecture (VISTA). None of the other automated information systems used by the VAMC were included in the contingency plan. For example, the plan did not list or prioritize the Automated Engineering Management System/Medical Equipment Management System or the Electronic Mail System (Exchange). In addition, the plan did not prioritize the individual applications within VISTA, which includes more than 100 different applications that support various clinical, financial, and administrative activities. If a disaster occurred that resulted in a limited or phased recovery, the absence of a detailed plan prioritizing the individual VISTA applications and the other major systems would force VAMC managers to prioritize the systems after the disaster, which could delay the restoration of some critical systems.

Support Resources. The contingency plan did not identify the equipment and staff resources needed to support the VAMC's critical information systems. If a disaster occurred, VAMC managers would need to quickly and efficiently allocate a limited amount of staff and equipment resources to ensure that critical systems were restored promptly. Without a detailed plan identifying the support resources needed for each critical system, VAMC managers would be forced to make difficult resource allocation decisions during the confusion of the recovery effort.

Alternative Processing Facility. The contingency plan did not include a designated alternative processing facility that could provide backup AIS services in the event that the primary facilities were severely damaged or could not be accessed.

Off-Site Backup Storage. The VAMC had not established an off-site storage location for critical backup files. These files were stored in a fireproof safe in the Information Resource Management Service and also at the VAMC's on-site warehouse in a non-fireproof cabinet. To ensure that critical files can be accessed in the event of severe damage to the entire VAMC, arrangements should be made for off-site storage at least 1 mile from the VAMC.

Conclusion. The VAMC Director needed to ensure that AIS contingency plans were revised to: (a) prioritize all major critical systems and individual VISTA applications; (b) identify the resources needed to support each system; (c) designate an alternative processing facility; and (d) establish an off-site storage location for critical backup files. The Director agreed and reported that the contingency plan would be revised to include the suggested improvements. The target date for completing the revision is February 15, 2001. The corrective actions are acceptable and we consider the issue resolved.

Fraud and Integrity Awareness Briefings

As part of the CAP review, we conducted six 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. About 150 VAMC 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 is 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 on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will 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.

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: November 14, 2000

From: Director, VA Medical Center Spokane, Washington (668/00)

Subj: Draft Report: Combined Assessment Program Review of VA Medical Center Spokane, Washington (Project No. 2000-02062-R8-266)

To: Assistant Inspector General for Auditing (52)

1. We have reviewed the draft OIG report for the Combined Assessment Program (CAP) review conducted August 21–25, 2000, at our facility. We are in full concurrence with all the conclusions noted in the report.

2. Attached please find our implementation plan addressing the issues identified in the CAP draft report. If you have questions or comments about the implementation, please contact Donna DeHart, administrative assistant to the chief of staff, at (509) 434-7204 or on e-mail.

(Original signed by:)
J. M. MANLEY

Attachment

VETERANS AFFAIRS MEDICAL CENTER, SPOKANE, WA: IG CAP IMPLEMENTATION PLAN

Subject	Corrective Action	Target Completion Date
Contract Nursing Home Care 1. Monthly Visits to patients in Contract Nursing Home Care	a. The CNH Program Coordinator will insure the required monthly visits are completed in the future.	Implemented 9/11/00
2. Contract Nursing Home inspection procedures include follow up on the correction of identified deficiencies.	a. Our VAMC policy has been revised to include the identification and approval of needed CNH facilities, process for initial and annual inspection of such facilities, and the review and correction of identified deficiencies from such inspections.	Implemented 10/1/00
Staffing, Pharmacy and Clinic Appointment Scheduling-- Various Issues and Concerns Should be Addressed 1. Staffing Issues Raised by Employees	a. FY01 budgets have been developed with managers making adjustments when needed to meet workload demands. b. Service clinic chiefs will reassess staffing needs and present to Clinical Executive and Quality Resource Boards as needs are identified. c. At the time of IG visit, Patient Care Services (118) was recruiting for 7.6 nursing FTEE. Only 2 full-time LPN positions still need to be filled, and then nursing will be at ceiling for FTEE.	10/1/00 Ongoing 10/1/00
2. Pharmacy Service	a. Pharmacy has hired an additional pharmacist and filled the IV pharmacy technician position. b. Prescription refills are now being handled by mail. c. A robot system will be installed. d. Recruitment is in process to fill Chief of Pharmacy position.	10/1/00 11/1/00 6/1/01 12/30/00

3. Waiting Times for Scheduling Clinic Appointments		
Primary Care	a. Team approach model in primary care is being refined.	12/8/00
	b. Clinical reminder package updated with education on use to staff.	11/20/00
	c. Physician assistant & primary care physician was hired.	12/30/00
Urologist	a. A full-time urologist has been hired pending the J-1 waiver process.	7/01/01
	b. We are working with contract urologist to reduce the backlog until the full urologist arrives.	10/15/00
Orthopedics	a. A full-time physicians assistant has been assigned to work in orthopedic clinic.	10/1/00
	b. Primary care providers have been educated in management of back pain, utilizing VA/DoD low back pain guideline.	10/1/00
Eye Care	a. An additional optometrist has been hired.	7/25/00
	b. A new eye clinic building will be opened in March 2000, with additional exam rooms and equipment to improve efficiency.	3/01/00

4. Patient and Employee Results		
One physician in charge of each inpatient's care	a. Business cards are being made for inpatient physicians to provide to patients and their families.	11/15/00
Not answering call lights within 5 minutes	a. Nurse managers addressed the issue of answering call lights in a timely manner with their staff.	10/1/00
	b. Additional staff has been hired.	11/1/00
Pain Management	a. Additional staff education is being done regarding pain management.	10/30/00
Employee dissatisfaction with awards process	a. Award funding has been increased and moneys decentralized to service chiefs so that awards can be granted as needed throughout the year.	11/15/00
87% of employees are comfortable reporting their own errors	a. An Error Prevention Process Action Team has been appointed. An anonymous voicemail system has been established to facilitate the reporting of errors.	10/30/00

Appendix II

OPPORTUNITIES FOR IMPROVING THE QM PROGRAM

Subject	Corrective Action	Target Completion Date
Strategic Planning, Medication Usage Evaluations, and Monthly Operating Report		
1. Strategic Planning	a. Criteria-based prioritization will be incorporated into future planning processes.	11/1/01
2. Medication Usage Evaluations	a. The P&T Committee has initiated reporting on ADRs and has begun monitoring of MUEs. Examples of current MUEs being done are proton pump inhibitors and lipid lowering agents.	10/1/00
3. Monthly Operating Report (including recommendations from focused reviews and special action groups to raise awareness and assist with tracking.)	a. Recommendations from special studies will be included in the MOR in the future.	11/30/00
4. Include Goals for each MOR element	a. Targets and/or thresholds for each element have been added to the Monthly Operating Report.	8/25/00

OPPORTUNITIES FOR IMPROVING MANAGEMENT CONTROLS

Subject	Corrective Action	Target Completion Date
Controlled Substance Inspections	***General Note: As part of the expansion of the pharmacy staff, a technician was permanently assigned to the controlled substance vault, rather than having staff rotate through the area. In so doing, several deficiencies have been addressed and solved due to more consistent coverage.***	
1. Inspection procedures did not cover excess, returned, or unusable controlled substances stored in the pharmacy vaults.	a. Counting of these items was added to the Inspector's policy and will be made a part of future inspections.	10/1/00
2. Inspector did not review expiration dates during this inspection of the pharmacy vault.	a. All expiration dates and lot numbers were updated following this review. Also, as part of the receipt process for controlled substances, the technician now updates the lot number and expiration date as new shipments are received.	10/1/00
3.Some "green sheets" were unaccounted for during the ward inspection.	a. The process for handling "green sheets" has been changed to assign responsibility for reconciling the count to the inpatient pharmacy supervisor in collaboration with the clinical assistant for Patient Care Service.	10/1/00
4. A pharmacist performed the physical counts of the controlled substances in the pharmacy vault and nurses performed the counts of the controlled substances on the hospital wards.	a. The policy will be revised to require physical counts to bed done by the inspector.	12/1/00
5. The VAMC listing of controlled substance inspectors showed that one of the inspectors was a nurse.	a This individual has been removed from the list of inspectors.	10/1/00
6. Controlled substances were not placed in the vault promptly after receipt.	a. Employees have been instructed to Secure all drugs I the vault as part of the "receipt" process in the future.	10/1/00
7. The vault door was observed at various times to be open.	a. The vault door is now closed at all times.	10/1/00

Service Contract---The Ground Ambulance contract Should Be Renegotiated and Effectively Monitored		
1. New ground ambulance contract is negotiated that accurately establishes service requirements.	a. A modification has been issued to the existing contract to change the estimated requirements to reflect actual usage.	11/1/00
2. Negotiate cost-effective flat rates for trips outside the Spokane City limits.	a. A flat rate has been negotiated for trips to Seattle and Portland. A modification has been issued to the existing contract to reflect this change.	11/1/00
3. All ambulance trips are properly authorized in writing.	a. Ambulance trip authorizations are now done totally in writing and CPRS is utilized routinely.	11/1/01
4. HCAS (136) staff receive training on preparing VA Forms 4-1358/reconciling the forms with contractor bills.	a. The new travel clerks have received training regarding preparation of VA Form 4-1358, authorizing ambulance travel, and the reconciling of bills process has been restructured.	11/1/01

Supply Inventory Management--Excess Inventories Should Be Reduced and Controls Enhanced			
1. Medical	a. AN&MM (90) will review the current process of setting normal stock levels for medical supplies. All levels set too high and generating an excess inventory will be adjusted downward.	11/30/00	
	b. AN&MM will review the process of stocking inactive items. A mechanism will be put in place to ensure inactive items are not routinely stocked.	11/30/00	
	c. AN&MM will continue to use the Generic Inventory Program (GIP) automated inventory management system to reduce supply inventories to levels consistent with current needs.	Ongoing	
2. Prosthetics	a. Prosthetics will review normal stock levels for all other items and reduce levels where appropriate.	10/1/00	
	b. AN&MM will review their order levels of prosthetics items.	10/1/00	
	c. AN&MM will continue using the GIP automated inventory management system for prosthetic supplies to reduce supply inventories to levels consistent with current needs.	Ongoing	
3. Engineering Supplies	a. AN&MM (90) and ETS (138) will include selected items of Engineering supplies in the Generic Inventory Program (GIP).	4/1/01	
4. Pharmaceutical Supplies	a. Pharmacy has been designated as a secondary order point and will begin using the GIP for replenishment of supplies.	10/1/00	
	b. A full-time pharmacy application coordinator has recently been appointed and he will begin using the Drug Accountability package to automate inventory management in Pharmacy.	3/1/01	

Information Technology Security Contingency Plans Should Be Revised			
1. Prioritization of Critical Systems	a. The Information Technology Security Contingency Plan will be revised to include the prioritization of major AIS systems and	2/15/01	
2. Identification of Support Resources	a. Staffing and equipment resource plans to support critical information systems will be added to the plan.	2/15/01	
3. Designation of Alternative Processing Facility	a. An Alternate processing facility will be identified.	2/15/01	
4. Establish Off-Site Backup Storage	a. An Off-site storage location will be established and utilized for critical backup files.	2/15/01	

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