



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Bay Pines, Florida

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.

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline - (800) 488-8244**

Contents

	Page
Executive Summary	i
Introduction	1
Medical Center Profile	1
Objectives and Scope of CAP Review	1
Results of Review	3
Organizational Strengths	3
Opportunities for Improvement	3
Controlled Substances Security	3
Crash Carts	4
Environment of Care	5
Government Purchase Card Program	6
Automated Information Systems Security	7
 Appendices	
A. VISN 8 Director Comments	9
B. Medical Center Director Comments	10
C. Report Distribution	15

Executive Summary

Introduction

During the week of January 13-17, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center Bay Pines, Florida. 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. In conjunction with the CAP review, we provided fraud and integrity awareness training to 521 employees.

Results of Review

Patient care activities reviewed were generally operating satisfactorily; however, financial and administrative activities reviewed needed some improvement. The Pain Management Program was comprehensive and well organized. There were no reportable conditions found in the areas reviewed in contract administration, clinical laboratory security, community-based outpatient clinics (CBOCs), management of violent patients, Patient Advocate Program, patient waiting times, and QM. The Veterans Integrated Service Network (VISN) Director needs to ensure that the Medical Center Director improves:

- Internal controls over controlled substances security.
- Control and accountability for replenishing crash carts.
- Safety and cleanliness of some areas of the medical center.
- Internal controls over the Government Purchase Card Program.
- Automated information systems (AIS) security.

VISN Director Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. (See pages 9-14 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. VA Medical Center Bay Pines is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven CBOCs located in Clearwater, Naples, Manatee, South St. Petersburg, Sarasota, Port Charlotte, and Avon Park, Florida. In addition, there is a large, multi-service outpatient clinic in Ft. Myers, Florida. The medical center is part of VISN 8 and serves a veteran population of about 322,000 in a primary service area that includes 9 counties in Florida.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 202 operating hospital beds, 112 nursing home operating beds, and 104 domiciliary beds. The medical center also operates several regional referral and treatment programs, including a Residential Day Treatment Program for Sexual Trauma and a Women's Health Program.

Affiliations and Research. The medical center is affiliated with the University of South Florida College of Medicine and the Nova Southeastern University School of Osteopathic Medicine, and supports 23 medical resident positions in 13 training programs. In fiscal year (FY) 2002, the medical center research program had 11 projects and a budget of over \$1 million. Areas of research include neuroscience, nephrology, and cardiology.

Resources. In FY 2002, medical care expenditures totaled about \$249 million. The FY 2003 medical care budget is about \$271 million. FY 2002 staffing totaled 2,380 full-time equivalent employees, including 169 physicians and 625 nurses.

Workload. In FY 2002, the medical center treated 70,215 unique patients. The medical center provided 57,978 inpatient days of care in the hospital; 38,530 inpatient days of care in the Nursing Home Care Unit (NHCU); and 33,716 inpatient days of care in the Domiciliary. The inpatient care workload totaled 8,302 discharges and the average daily census was 159 for the hospital, 106 for the NHCU, and 92 for the Domiciliary. The outpatient workload was about 665,000 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, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices and conditions. 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, and patients; and reviewed clinical, financial, and administrative records. The review covered the following programs and activities:

Automated Information Systems Security	Laboratory Security (Clinical and Research)
Community-Based Outpatient Clinic Operations	Management of Violent Patients
Contract Award and Administration	Pain Management Program
Controlled Substances Security	Patient Advocate Program
Crash Carts	Patient Waiting Times
Environment of Care	Quality Management
Government Purchase Card Program	

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 survey results were provided to medical center management.

During the CAP review, we also presented four fraud and integrity awareness briefings for medical center employees. A total of 521 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.

The review covered medical center operations for the period October 1, 2001, through January 13, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strengths

The Pain Management Program Was Well Organized and Comprehensive. Clinicians regularly assessed patients' pain levels along with routine vital signs and documented the pain levels in the medical records. The Nurse Executive provided daily reports at the Director's morning staff meeting on patients with pain levels of four or greater. The Chief of Staff discussed the management of the patients with their respective medical teams to ensure appropriate and timely follow-up.

The medical center further enhanced the program by assessing patients' spiritual and psychological pain as well as their physical pain. The medical center initiated "Quality of Life Rounds" during which patients identified as having significant issues with emotional and/or physical pain were visited by an interdisciplinary team. The team met with patients at their bedsides and, when possible, met with their families. Pain treatment options were discussed, and patients were allowed to direct the course of their treatments to the extent possible.

Opportunities for Improvement

Controlled Substances Security – Improve Internal Controls Over Controlled Substances

Conditions Needing Improvement. Internal controls over Schedule II-V controlled substances were weak. A loss of a Schedule II controlled substance went undetected because inspection procedures were inadequate and separation of duties was not established.

Monthly Unannounced Controlled Substances Inspections. Inspectors did not compare receiving reports to the receipts posted in the inventory records during monthly inspections.

Separation of Duties. The receipt of controlled substances for both the inpatient and outpatient pharmacies was the sole responsibility of the Pharmacy Service program manager. According to Veterans Health Administration (VHA) policy, two individuals, the accountable officer or a designee, and the employee responsible for receiving the controlled substances should witness receipt of controlled substances. One employee acknowledging the receipt of controlled substances weakens internal controls over the receipt of controlled substances.

Physical Security of Controlled Substances. VHA policy requires that electronic access control systems be installed to monitor access to areas where controlled substances are stored in large quantities. The medical center's inpatient vault had a key entry system (not the required electronic card entry system) and a closed-circuit camera to monitor access to the vault that was not functioning. Police Security Surveys conducted annually for the past 3 years addressed the

need for Pharmacy Service to install an electronic card entry system to gain access to the inpatient vault.

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

- a. Controlled substances inspectors are trained in the proper procedures for conducting inspections.
- b. Inspectors verify the validity of the physical counts with receipt and distribution documents.
- c. Two employees acknowledge the receipt of controlled substances.
- d. The inpatient vault closed-circuit camera is functioning and an electronic card entry system is installed.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed 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.

Crash Carts – Improve Controls and Accountability for Replenishing Essential Items

Conditions Needing Improvement. Review of Quarterly Code Blue Quality Service Reports for FY 2002 showed that supplies needed by clinicians to treat cardiopulmonary resuscitation emergencies were frequently missing from crash carts (intravenous tubing, gloves, tape, and suction devices). Crash carts are required to contain the essential medications, equipment, and supplies to perform basic and advanced life support procedures.

During calendar year 2002, missing supplies were reported in each quarter, and each report indicated that the Supply Processing and Distribution (SPD) supervisor had committed to correcting these deficiencies. However, corrective action has not occurred. The SPD supervisor needs to ensure that crash carts are properly replenished with essential supplies.

Recommended Improvement Action 2. The VISN Director should ensure that the Medical Center Director improves controls over, and accountability for, the proper stocking of essential supplies on crash carts.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed 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.

Environment of Care – Improve Safety and Cleanliness of Some Areas of the Medical Center

Conditions Needing Improvement. Areas inspected were generally free of safety hazards and were clean, except the Domiciliary and the Veterans Canteen Service (VCS).

To assess the safety and cleanliness of the medical center, we inspected the following areas with the Chief, Facilities Support Service (FSS), and responsible management officials for each area:

Inpatient unit 5A	Emergency room
NHCU A and B	Hemodialysis unit
Rehabilitation and subacute care unit 5C	Domiciliary
Inpatient psychiatry unit 1-4	Bayside and Geriatric Primary Care Clinics
Gero-psychiatry unit 1-5	Primary Care modules
Medical intensive care unit (MICU)	Urgent care areas
Cardiac care unit	Ancillary and support areas
Surgical recovery room	Food and Nutrition Service kitchen
Ambulatory surgery unit	

In addition, we inspected the VCS retail store, food service preparation area, and customer dining area.

Safety Hazards. The following safety hazards were identified:

- A scalpel was laying on the floor in a public hallway near the MICU.
- Oxygen, propane, or carbon dioxide tanks were not secured in inpatient unit 5A, inpatient psychiatry unit 1-4, the NHCU patio, and the VCS.
- Unoccupied beds in the Domiciliary had mattresses with torn and tattered surfaces.
- Floors in several areas of the Domiciliary and the VCS were wet.
- Floors in the Domiciliary storage rooms were cluttered.
- A VCS employee was restocking plastic utensils without wearing gloves.
- Cleaning products were not secured in the VCS customer dining area.
- A coiled equipment hose was in the walkway between the VCS food preparation and food cooking areas.
- The VCS did not monitor refrigerator and freezer temperatures.
- Some food items in the VCS retail store were out-of-date.

Cleanliness of Areas. The Domiciliary and all areas of the VCS required cleaning.

Conditions observed in the Domiciliary:

- Food debris and drink spills were observed in common areas.
- Refrigerators were not clean.
- Tabletops and floors in dayrooms and common areas were dirty.

- Air ventilation system covers in Section C were dusty.
- Ceiling tiles were stained and damaged.

Conditions observed in the VCS:

- Debris was observed in the refrigerator case in the retail store.
- Shelves stocked with retail items were dirty and dusty.
- Employee hand-washing sinks, refrigerator and freezer doors and linings, customer dining area tables, and retail store carpeting were dirty.
- Food residue was observed on food scales and can openers.
- Trash receptacles in the food preparation area were uncovered.
- Dishtowels were stored in an open area under cooking equipment.
- Food trays placed in the food service area for customers to use were wet and dirty.

We discussed the safety and cleanliness deficiencies observed with the Medical Center Director, the Chief, FSS, and responsible management officials for each area. We provided medical center management with a synopsis of the deficiencies identified during our inspection. Management initiated immediate corrective actions.

Recommended Improvement Action 3. The VISN Director should ensure that the Medical Center Director takes action to ensure:

- a. Safety and cleanliness deficiencies identified during our inspection are corrected.
- b. Patient care, food preparation, and common areas are routinely inspected and kept in a safe and clean condition.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed 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.

Government Purchase Card Program – Strengthen Controls Over the Purchase Card Program

Conditions Needing Improvement. During the 13-month period ending October 31, 2002, purchase cardholders made about 29,000 transactions totaling \$15 million. At the time of our review, the Purchase Card Coordinator was part-time and had been performing the coordinator duties for about 3 months. The following four areas require management attention:

Cardholders Did Not Have Required Procurement Warrants. VA policy requires that cardholders with purchase limits exceeding the micro-purchase threshold of \$2,500 receive appropriate training and procurement warrants for their level of purchasing authority. We found 6 cardholders without warrants who had 61 purchase cards with single purchase limits ranging

from \$5,000 to \$100,000, including 3 cardholders that made purchases exceeding the micro-purchase threshold.

Purchase Cards of Former Employees Were Not Cancelled. The purchase cards of 22 former employees were not cancelled when they left employment with the medical center. The Purchase Card Coordinator notified Citibank and 187 purchase card accounts for the 22 former employees were cancelled. VA policy requires that the Purchase Card Coordinator cancel all cards when a cardholder terminates employment with the medical center.

Cardholders and Approving Officials Had Not Received Required Training. According to training records, 9 cardholders and 17 approving officials had not received the required training. VHA policy requires that the Purchase Card Coordinator ensure that cardholders and approving officials receive required training prior to the issuance of purchase cards.

Quarterly Audits of Cardholder Accounts Were Not Conducted. Fiscal or Acquisition & Materiel Management Service staffs were not performing quarterly audits of cardholder accounts. VHA policy requires quarterly audits of all cardholder accounts that are not reviewed during monthly statistical sampling audits conducted for the VA Financial Service Center. Some of the deficiencies identified during our review would have been detected and/or prevented through quarterly audits of cardholder accounts.

Recommended Improvement Action 4. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

- a. Warrants are issued to all cardholders with spending limits exceeding the micro-purchase threshold of \$2,500.
- b. Government purchase cards are cancelled when cardholder employment is terminated.
- c. Cardholders and approving officials are trained, as required.
- d. Quarterly audits are conducted of all cardholder accounts not reviewed during the monthly audits conducted for the VA Financial Service Center.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed 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 – Security Needs Improvement

Conditions Needing Improvement. The following AIS security conditions require management attention:

Sensitive Information on Shared Network Drives Was Not Appropriately Protected. Sensitive patient information, containing patient names, social security numbers, medical conditions, and

patient identification pictures was stored on a shared network drive and accessible to all employees. VA policy requires that sensitive patient data be treated as confidential and protected from general disclosure. Management had not developed a policy addressing the use of shared drives and did not routinely review shared drives for sensitive information.

Physical Security of the Telephone Switch Room Needed Improvement. The telephone switch room could be accessed by climbing up and over the wall in an adjacent FSS storage room. VA policy requires that this type of access be blocked in order to secure sensitive communication (Private Branch Exchange) equipment.

Monitoring of Remote Access Needed Improvement. Quarterly reviews of the continued need for remote access were not performed, as VA policy requires. The medical center had 309 remote access users as of January 13, 2003. At our request, Information Systems Service staff reviewed the current users continued need for access and terminated access for 112 users.

Recommended Improvement Action 5. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

- a. Procedures are developed to protect the confidentiality of patient information stored on a shared drive.
- b. Overhead access is blocked to the telephone switch room.
- c. Quarterly reviews of the continued need for remote access are performed.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed 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.

VISN 8 Director Comments



DEPARTMENT OF VETERANS AFFAIRS
VA Sunshine Healthcare Network
VISN 8
P. O. Box 406
Bay Pines, FL 33744
Office: (727) 319-1125 Fax: (727) 319-1135

June 18, 2003

In reply refer to:

James R. Hudson
Director, Atlanta Audit Operations Division
1700 Clairmont Road
Decatur, GA 30033

SUBJ: Draft Report – Combined Assessment Program Review of the Bay Pines VA Medical Center, Bay Pines, Florida – Project no. 2003-00700-R3-0047

Dear Mr. Hudson:

Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the Bay Pines VA Medical Center.

Enclosed is the final response from Bay Pines VA Medical Center relating to the above subject matter.

Sincerely,

A handwritten signature in black ink, appearing to read "E. Headley".

Elwood J. Headley, M.D.
Network Director, VISN8

Enclosure

Medical Center Director Comments

Combined Assessment Program Review –VA Medical Center, Bay Pines, FL (Project No. 2003-00700-R3-0047)

Opportunities for Improvement: Controlled Substances Security – Improve Internal Controls Over Controlled Substances

The VISN Director should ensure that the Medical Center Director takes action to ensure that:

- a. Controlled substances inspectors are trained in the proper procedures for conducting inspection.

Concur. However, it is important to note that training for inspectors was being conducted by the medical center. The required subject matter is now being included in all training. Special emphasis is given regarding the matching of invoices for controlled substances received from the prime vendor and the electronic entry in the dispensing log.

- b. Inspectors physically count controlled substances and verify the accuracy of the counts with receipt and distribution documents.

Concur. Inspectors physically count controlled substances and match the counts with purported inventories, and we are placing special emphasis on the function of matching these counts with inventory receipt documents.

- c. Two employees acknowledge the receipt of controlled substances.

Concur. Two employees, the accountable officer and a designated responsible official, now share responsibility for receipt of all controlled substances.

- d. An electronic card entry system is installed.

Concur. An electronic card system was installed in April on the inpatient pharmacy vault door.

Appendix B

Opportunities for Improvement – Crash Carts – Improve Controls and Accountability for Replenishing Essential Items

The VISN Director should ensure that the medical center improves controls over, and accountability for, the proper stocking of SPD items on crash carts.

Concur. The following are examples of improvements implemented: a drawer by drawer inventory list now accompanies each cart and is followed during each replenishment; two SPD employees inventory and replenish the carts for a “double check”; each cart is now being inspected every 24 hours to ensure that the lock is still secure and external items are in place.

Opportunities of Improvement – Environment of Care – Improve Safety and Cleanliness of some areas of the Medical Center

The VISN Director should ensure that the Medical Center Director takes action to ensure:

- a. Safety and cleanliness deficiencies identified during the inspection are corrected.

Concur. The areas cited by the IG CAP team have been resolved, including replacement of torn and dirty mattresses in the Domiciliary. Dom management has also been changed and new management has met with FSS management and developed a plan of action to resolve all concerns voiced by Dom patients and staff. A roof project is scheduled to begin in August 2003 that should help resolve several of the environmental issues. Current medical center management is much more pro-active and supportive of the Domiciliary and will once again provide the required resources necessary to make the Domiciliary an effective and viable program.

- b. Patient care, food preparation, and common areas are routinely inspected and kept in safe and clean condition.

Concur. With regard to cleanliness and safety in the Veterans Canteen Service, Medical Center management recognized problems in the fall of 2002. Calls were initiated to VCS in Washington and a District supervisor visited shortly after. VCS also recognized significant problems in its operation and initiated a change in management. This was accomplished in late January. While problems were discovered during the IG’s visit, new VCS management has made significant improvement in overall Canteen operations, cleanliness and food preparation. VCS management is providing more and better training of its staff with regard to proper cleanliness and food safety procedures. Monitors and regular inspections have been established to prevent re-occurrences. In addition, work orders have been submitted to Facility Support Service for those items needing repair or replacement and stock room

Appendix B

areas have been reorganized to meet fire and safety requirements. In the Domiciliary, FSS and Dom management have met and developed a plan of action and responsibility to assure that it is clear who, patients or staff, have which responsibilities. A major issue cited was the leaking ceiling tiles. This problem will be corrected when the Dom roof is replaced with a project scheduled to begin in August 2003.

Opportunities for Improvement – Government Purchase Card Program – Strengthen Controls over the Purchase Card Program

The VISN Director should ensure that the Medical Center Director takes action to ensure that:

- a. Warrants are issued to all cardholders with spending limits exceeding the micro-purchase threshold of \$2,500.

Concur. All warrants have been issued.

- b. Government purchase card accounts are cancelled when cardholder employment is terminated.

Concur. All accounts of former cardholders identified by the OIG have been cancelled. In addition, all other cardholder accounts have been reviewed and a total of 326 cards have been deactivated. At this time, Bay Pines is confident that all cardholder records are up to date. In addition, a process that requires any employee leaving Bay Pines' employment, must clear through the Purchase Card Coordinator to assure that if they have a Purchase Card, it is taken back and the employee's name removed from the system.

- c. Cardholders and approving officials are trained, as required.

Concur. An Acting Purchase Card Program Coordinator was detailed to that position on October 21, 2002. All staff receiving cards issued after that date have received and documented this training. All other cardholders are under review to determine if training was given. It appears that while training was given, for the 9 cardholders and 17 management officials identified by the IG, there was no documentation to support that such training had occurred. However, Bay Pines is confident that training actually did occur because cards and computer menu access would not have been granted without such training. A review of all training records is ongoing and all required training will be completed by July 1, 2003.

- d. Quarterly audits are conducted of all cardholder accounts not reviewed during the monthly audits conducted for the VA Financial Service Center.

Appendix B

Concur. A full time Purchase Card Program Coordinator has been selected. She, and an Accountant in Fiscal, have developed a review system and schedule to assure all active cardholder accounts are audited. This new process is currently underway.

Opportunities for Improvement – Automated Information Systems Security – Security Needs Improvement.

The VISN Director should ensure that the Medical center Director takes action to ensure that:

- a. Procedures are developed to protect the confidentiality of patient information stored on a shared drive.

Concur. The shared drive contains approximately 22,500 images of veterans with names and SSN. No clinical data is viewable. The file's sole function is to present a photograph of the veteran during a missing patient search. The IG Inspectors both agreed that the process would help in identifying missing veterans but did not want all staff viewing the data. Again, there is no administrative or clinical data present except for name and SSN. Prior to the visit from OIG, the file was accessible by all staff, but rarely accessed by any staff. After the objection from OIG, the facility (OIG and ISS) agreed to:

1. Remove the folder from view on the server. The file has been hidden.
2. Restrict access to only those persons who currently have access to Vista patient records and/or CPRS. This included only persons who currently access or may need to access a patient's record for official work functions. This has been done.

- b. Overhead access is blocked to the telephone switch room.

Concur. A project is currently under development that will restrict access to the telephone switch room. The project should be completed within 6 months.

- c. Quarterly reviews of the continued need for remote access are performed.

Concur. IRM at Bay Pines has never received any information to indicate Remote Access Server (RAS) required quarterly reviews. However, it is the facility's policy to change passwords every 90 days. In reviewing this issue with the Network Administrator and other facility Network Administrators, no tool could be found that would allow for any automated review process. The IG Inspector asked if it would be reasonable to send a request to individual services for review of all RAS accounts. He thought that there should be a monitor in this area and that, with one developed, could be used as a standard OIG would use for other facilities. Bay Pines concurred and

Appendix B

initiated the procedure. The first report was forwarded to this Inspector in February 2003. This change was acceptable to both the IG Inspector and the Team Leader during their visit.

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Deputy Chief of Staff (00A1)
Executive Secretariat (001B)
Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
Office of the Medical Inspector (10MI)
Director, National Center for Patient Safety (10X)
Deputy Under Secretary for Health for Operations and Management (10N)
VHA Chief Information Officer (19)
Veterans Integrated Service Network Director (10N8)
Director, VA Medical Center Bay Pines, FL (516/00)

Non-VA Distribution

Office of Management and Budget
General Accounting Office
Senator Bob Graham
Senator Bill Nelson
Congressman Bill Young
Congressman Michael Bilirakis
Congressman Porter Goss
Congressman Mark Foley
Congressman Adam Putnam
Congresswoman Katherine Harris
Congressional Committees (Chairmen and Ranking Members):
 Committee on Governmental Affairs, U.S. Senate
 Committee on Veterans' Affairs, U.S. Senate
 Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations,
 U.S. Senate
 Committee on Governmental Reform, U.S. House of Representatives
 Committee on Veterans' Affairs, U.S. House of Representatives

Appendix C

Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations,
U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs,
U.S. House of Representatives
Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on National Security, Emerging Threats, and International Relations,
Committee on Governmental Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans'
Affairs, U.S. House of Representatives

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.