Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Lebanon VA Medical Center Lebanon, Pennsylvania

Report No. 03-02577-62

January 12, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the period September 22 – September 26, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Lebanon VA Medical Center, which is part of the Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 124 employees and a drug diversion briefing to 15 pharmacy employees.

Results of Review

The Utilization Management (UM) program was comprehensive and effective. Medical center patient care, QM, resident supervision, and the patient informed consent process for clinical procedures were generally operating satisfactorily. The environment of care was properly maintained and laboratory and pharmacy security were sufficient. The facility's management of clinic waiting times and patient enrollment was adequate. Financial and administrative controls related to accounts receivable and medical care collections were also operating satisfactorily. To improve operations, the VISN and medical center management needed to:

- Ensure the initiation of background investigations for contracted physicians and improve contract file documentation.
- Implement controls to prevent physicians from engaging in conflict of interest situations.
- Establish controls to strengthen accountability and effectively manage the engineering supplies inventory.
- Strengthen accountability over controlled substances.
- Improve oversight of the Community Residential Care program.
- Correct information technology security deficiencies.
- Correct timekeeping for two part-time physicians.
- Properly maintain and utilize General Post Funds.
- Monitor the timeliness of internal reviews of Personal Funds of Patients accounts.

VISN 4 and Medical Center Directors' Comments

The Acting VISN 4 and Acting Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11-17 for the full text of the Directors' comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions. This report was prepared under the direction of Thomas L. Cargill, Jr., Director, Bedford Audit Operations Division, and Jacqueline Stumbris, CAP Review Coordinator, Bedford Audit Operations Division.

original signed by:
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in Lebanon, Pennsylvania, the Lebanon VA Medical Center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in Camp Hill, Lancaster, Reading, York, and Pottsville, Pennsylvania. The medical center serves a veteran population of about 200,000 in a primary service area that includes 13 Pennsylvania counties.

Workload. In Fiscal Year (FY) 2002, the medical center treated 30,170 unique patients, a 9 percent increase from FY 2001. The increase in patients was managed by adding evening clinic hours and additional staff. The inpatient care workload totaled 2,266 discharges, and the average daily census, including nursing home patients, was 222.9. The outpatient workload was 231,986 visits.

Resources. In FY 2002, medical care expenditures totaled $95 million. FY 2003 medical care expenditures totaled $109 million, 15 percent more than FY 2002 expenditures. The increase included additional VISN funding to reduce the medical center's waiting list. FY 2002 staffing was 945 full-time equivalent employees (FTEE), including 30 physician and 301 nursing FTEE.

Programs. The medical center provides medical, surgical, mental health, geriatric, and advanced rehabilitation services. The medical center has 134 beds (71 hospital and 63 Psychosocial Residential and Rehabilitation Treatment Program beds) and 136 nursing home beds. The medical center also provides physical examinations and emergency care to the Pennsylvania National Guard.

Affiliations and Research. The medical center is affiliated with the Pennsylvania State University (Penn State) College of Medicine at the Hershey Medical Center and supports 27.6 medical resident positions in the following specialties: Anesthesiology, Cardiology, Radiology, Family Practice, General Internal Medicine, Medicine, General Surgery, Oncology, Ophthalmology, Psychiatry, and Urology. In FY 2003, the medical center research program had 14 projects and a budget of $869,000. Major areas of research include optometry, cardiovascular disease, nephrology, and stroke prevention.

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 of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered facility operations for FY 2002 and FY 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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 activities:

Accounts Receivable
Clinic Waiting Times and Enrollment
Clinical Contracts
Community Residential Care Program
Controlled Substances Accountability
Environment of Care
Engineering Supplies Accountability
General Post Funds
Information Technology Security
Informed Consent for Clinical Procedures
Laboratory Security
Medical Care Collections Fund
Personal Funds of Patients
Pharmacy Security
Physician Conflict of Interest
Quality Management
Resident Supervision
Timekeeping for Part-time Physicians
Utilization Management 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. Questionnaires were sent to all medical center employees, 51 of whom responded. We also interviewed 30 patients during the review. The survey indicated generally high levels of patient and employee satisfaction and did not disclose any significant issues. The full survey results were provided to medical center management.

During the review, we presented five fraud and integrity awareness briefings and one drug diversion briefing to medical center employees. The fraud and integrity awareness briefings, attended by 124 employees, 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 drug diversion briefing was attended by 15 pharmacy employees and covered an awareness of the most commonly diverted controlled substances, prevention of diversions, and case specific examples of drug diversions.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–10). For these activities, we

make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies identified.

Results of Review

Organizational Strengths

Utilization Management Program

The UM program was comprehensive. The medical center had an effective UM program to monitor admissions and continued stay appropriateness. All acute care admissions and continued stay days were reviewed against VA criteria. The UM Coordinator collected data by service and diagnosis, comparing results with VISN, national VA, and Medicare data. Even though all areas met or exceeded established goals, the coordinator noted and trended possibilities for further improvement. Clinical service chiefs made recommendations to further improve performance, which included initiatives to improve the collection of third-party reimbursement funds.

Opportunities for Improvement

Clinical Contracts

Condition Needing Improvement. A review of a sample of 11 scarce medical specialist service (SMSS) contracts valued at $4.7 million identified the following issues that required management attention:

- Background investigations for 13 physicians contracted to provide radiology and dermatology services had not been initiated as of September 23, 2003. These physicians had provided services for over 11 months. In addition, background investigations for 26 physicians contracted to provide urology, ophthalmology, cardiology, and anesthesiology services were not initiated prior to contract performance. Background investigations for these 26 physicians were initiated approximately 2 months after the contracts were initiated.

- Although the contracting officer stated that analysis and research was performed, required documentation was missing from SMSS contract files including:

    - Workload analysis to support the need and level of procurement (10 contracts valued at $2.2 million).

    - Market research to assess the market capability to satisfy specialty needs (10 contracts valued at $2.2 million).

    - Price negotiation memoranda documenting the purpose of the negotiation, description of the acquisition, the name, position, and organization of each person representing the contractor and the government in the negotiation, a summary of the contractor's proposal

and the Government's negotiating position, and documentation of fair and reasonable pricing (4 contracts valued at $1.1 million).

Recommended Improvement Action(s) 1. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires: (a) contracting officers to initiate background investigations prior to contract performance and (b) contracting officers to ensure contract files contain all required documentation.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans, which included creating a log to track background investigations and requiring the contracting officer to certify that background investigations have been initiated. The target date for completing this action was December 1, 2003. In addition, the Acting Medical Center Director reported that a Contract File Checklist was developed during October 2003 to ensure all of the required documentation was included in the contract files. We consider this issue closed.

Physician Conflict of Interest

Condition Needing Improvement. During our review of 11 SMSS contracts we noted a possible conflict of interest situation that required management attention. The former Chief of Staff (COS), whose tenure with the medical center ended in June 2003, held a non-remunerative academic appointment as an Associate Professor of Clinical Medicine with the affiliate, Pennsylvania State University College of Medicine at the Hershey Medical Center. The former COS personally and substantially participated in the development of 5 of the 11 sampled SMSS contracts in our review. These included the SMSS contracts for urology, ophthalmology, cardiology, anesthesiology, and dermatology services. Specifically, she:

- Contributed to the recommendations to contract with the affiliate;
- Reviewed and approved changes to the statements of work; and
- Contributed to negotiations of scheduling, pricing, and billing.

The Executive Leadership Board (ELB) of the medical center considered the appointment of the COS as an Associate Professor at the affiliate an honorary appointment. For this reason the ELB felt that no conflict of interest on the part of the former COS existed, and did not seek regional counsel advice on this matter. Because the former COS had a faculty appointment, an imputed financial interest existed and her participation in the development of a VA contract with the affiliate was prohibited.

Recommended Improvement Action(s) 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that conflict of interest issues are prevented on all contracts with the affiliate.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. The Acting Medical Center Director reported that as of October 1, 2003, all medical staff had been informed that a conflict of interest develops when they have an appointment with the affiliate and are requested to enter

into the process of negotiating scarce medical service contracts with the Pennsylvania State University College of Medicine at the Hershey Medical Center. If issues arise involving the medical staff with the affiliate in the negotiating process, the Acting Medical Center Director will follow established guidelines for seeking Regional Counsel advice. We consider this issue closed.

Engineering Supplies Accountability

Condition Needing Improvement. Medical center management needed to establish controls to strengthen accountability and effectively manage engineering supplies inventory. The following conditions required management attention:

- Facilities Management Service (FMS) staff did not conduct VA's required annual physical inventories of engineering supplies.
- FMS managers were not utilizing VA's automated Generic Inventory Package (GIP) or any manual system to manage engineering supplies. The quantities and dollar value of engineering supplies on-hand could not be readily determined. As a result, it was not possible to effectively manage engineering supplies and ensure that supplies on-hand were appropriate to meet medical center needs. The medical center spent $592,808 on engineering supplies during FY 2003.

Recommended Improvement Action(s) 3. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) FMS staff conduct a physical inventory of engineering supplies to obtain an accurate count of all items to be included in the GIP system and (b) FMS managers implement GIP to monitor engineering supplies.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. The Acting Medical Center Director reported that a physical inventory of engineering supplies was being completed and that all inventory items will be loaded into GIP by December 30, 2003. We will follow up on the planned actions until they are completed.

Controlled Substances Accountability

Condition Needing Improvement. Controlled substances policies, inspection procedures, and inventory controls needed improvement. The following conditions required management attention:

- Medical center policy did not require that the Director notify the OIG Office of Investigations and the medical center Police Service of any suspected diversions of controlled substances. Also, the local accountability policy did not include procedures for ordering and receiving controlled substances, or for handling controlled substances prescriptions not picked up in the outpatient pharmacy by the close of the business day.

- Pharmacy Service did not maintain documentation of 72-hour inventories for 2 years, as required by VA policy. The documentation of the 72-hour inventories was destroyed after monthly controlled substances inspections were completed.

- Monthly inspections of controlled substances held for destruction were not properly conducted. During FY 2003, required monthly inspections were not conducted until May 2003. Additionally, inspectors were not using the correct inventory report, *Drugs Held for Destruction Report,* when conducting monthly inspections. The reliability of the inventory records they used for conducting inspections was questionable since there was no assurance that those records were complete and up to date.

Recommended Improvement Action(s) 4. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) local policies include written procedures for notifying the OIG Office of Investigations and the VA Police in the event of a controlled substances diversion, and local policies describe procedures for ordering and receiving controlled substances, and handling controlled substances prescriptions not picked up in the outpatient pharmacy by the close of the business day; (b) documentation of 72-hour inventories is maintained for 2 years; and (c) controlled substances held for destruction are inspected monthly using the proper inventory report.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. The Acting Medical Center Director reported that the medical center's controlled substances policy was being revised during the OIG site visit and he expected to sign the new policy by December 31, 2003. In July 2003, the medical center began maintaining documentation of the 72-hour inventories for the required 2-year period. Additionally, the *Drugs Held for Destruction Report* has been used for inspecting controlled substances held for destruction since the end of September 2003. We will follow up on the planned actions until they are completed.

Community Residential Care Program

Condition Needing Improvement. We interviewed Community Residential Care (CRC) program managers and reviewed a judgmental sample of 10 CRC records for compliance with fire and safety requirements. VA policy requires that an annual fire and safety inspection be conducted for each CRC home. Fire and safety inspections were conducted every 2 years rather than annually, as required. CRC program managers reported that they were not aware of the requirement for annual inspections and agreed to immediately begin annual inspections of the homes.

Recommended Improvement Action(s) 5. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that annual fire and safety inspections of all CRC homes be completed.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. The Acting Medical Center

Director reported that the annual fire and safety inspections of all homes included in the CRC program were completed by the end of September 2003. We consider this issue closed.

Information Technology Security

Condition Needing Improvement. The following information technology (IT) security deficiencies required management attention:

- An alternate data processing facility was not identified and included in the contingency plan for disaster recovery, as required by VA policy.
- Access to the computer room was not based on the employees' level of need. At the time of our site visit, 15 Information Resource Management (IRM) employees, whose level of need for access had not been evaluated, had access to the computer room.

Suggested Improvement Action(s) 1. We suggested that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) an alternate data processing facility be designated and added to the contingency plan, and (b) IRM employees' access to the computer room is limited based on the level of employee need.

The Acting VISN and Acting Medical Center Directors agreed with the findings and suggestions, and provided acceptable improvement plans. The Acting Medical Center Director reported that VISN IT staff are addressing the concern for alternate data processing facilities and action is expected to be completed by January 1, 2004. Tentatively, the medical center's alternate data processing site will be the Coatesville VA Medical Center. Additionally, the Chief Technical Officer recognized the need to decrease the number of staff with access to the computer room and has reduced the number of staff with access to the area from 15 to 12. We will follow up on the planned actions until they are completed.

Timekeeping for Part-Time Physicians

Condition Needing Improvement. Time and attendance controls for the medical center's nine part-time physicians were in place and generally operating in compliance with VA policy. However, two part-time physicians were working adjustable work schedules instead of fixed schedules as stipulated in their written time and attendance agreements. In addition, they did not obtain advance written approval from their supervisor to work the adjustable schedules, as required by VA policy.

Suggested Improvement Action(s) 2. We suggested that the Acting VISN Director ensure that the Acting Medical Center Director requires that part-time physicians obtain written supervisory approval in advance of working adjustable schedules.

The Acting VISN and Acting Medical Center Directors agreed with the findings and suggestions, and provided acceptable improvement plans. The Acting Medical Center Director reported that

as of October 1, 2003, all part-time physicians are monitored for adherence to their established fixed schedules and are required to check in upon arrival and at departure from the medical center. Additionally, a daily log of physician time spent on station in official capacity is maintained and reviewed each pay period. We consider this issue closed.

General Post Funds

Condition Needing Improvement. As of June 30, 2003, the medical center had 50 General Post Fund (GPF) accounts with a total dollar value of $1,455,151. These accounts were used to maintain gifts and donations for the benefit of patients or the medical center. According to VA policy, when funds have remained inactive for a period in excess of one year, a determination should be made as to whether it will be feasible to expend the funds in the manner specified by the donor. If expending the funds in the manner specified by the donor is not feasible, the funds must be transferred to the general-purpose account or returned to the donor. We noted that 4 of the 50 GPF accounts were inactive and were not being monitored to ensure appropriate utilization of the funds:

- Three GPF accounts with a total value of $60,542 remained inactive for over a year through the first week of September 2003 and no action had been taken to ensure these funds would be spent as intended by the donor. Following our discussion, medical center management stated that the balances of two of these accounts (valued at $38,542) would be used as intended by the donor.

- A fourth account established November 13, 2002, with a value of $112,171 remained inactive through the first week of September 2003. Fund control point officials and medical center management had no planned use for these funds. Following our discussion, medical center management informed us that a task force will be assigned to determine ways to effectively utilize the $112,171 as well as the third inactive account mentioned above valued at $22,000.

Suggested Improvement Action(s) 3. We suggested that the Acting VISN Director ensure that the Acting Medical Center Director monitors the utilization of GPF accounts.

The Acting VISN and Acting Medical Center Directors agreed with the findings and suggestion, and provided acceptable improvement plans. The Acting Medical Center Director reported that as of September 30, 2003, all GPF accounts were reviewed and letters were sent to all approving officials listed for Fund Control Points that have been inactive for one year or more. A spreadsheet has been developed to monitor this activity to identify inactive accounts on a timely basis. We consider this issue closed.

Personal Funds of Patients

Condition Needing Improvement. Patients who are treated at VA medical centers are able to keep personal funds on station during the course of their stay. Patients' personal funds are

maintained by the medical center in the form of individual Personal Funds of Patients (PFOP) accounts. As of September 3, 2003, the medical center had 189 individual PFOP accounts valued at $1,338,704.

PFOP accounts belonging to incompetent patients are designated as "Restricted" and are required to be reviewed at least every 6 months. The Patient Information Manager stated that reviews of restrictive accounts were not being done at all prior to our site visit. Health Administration Service (HAS) management informed us that they were implementing a tracking system to ensure restrictive accounts are reviewed as required.

Suggested Improvement Action(s) 4. We suggested that the Acting VISN Director ensure that the Acting Medical Center Director requires the performance of internal reviews of PFOP accounts.

The VISN and Acting Medical Center Directors agreed with the findings and suggestions, and provided acceptable improvement plans. The Acting Medical Center Director reported that a tracking system was completed to ensure all required PFOP accounts were evaluated every six months. All accounts were to be evaluated by December 15, 2003.

Appendix A

Acting VISN 4 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2003

From: Acting VISN Director

Subject: VA Medical Center Lebanon, Pennsylvania

To: Office of Inspector General

The Lebanon VA Medical Center carefully reviewed the recommendations and suggestions from their September 2003 Office of the Inspector General Combined Assessment Program review. Many of their strategies to address the identified concerns were in place at the time of the survey and were fine-tuned based upon their interaction with the site survey team.

As you will see in the attached report, several of the Lebanon VA Medical Center's corrective actions have been completed, are near completion, or are in the developmental phase.

Network 4 appreciated the opportunity to have the Office of the Inspector General once again visit one of our ten facilities. What they saw and heard from the talented Lebanon VA Medical Center staff again emphasizes their local strategic principle of "Put Veterans First".

CHARLEEN R. SZABO, FACHE

Acting Network Director

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 20, 2003

From: VA Acting Medical Center Director

Subject: VA Medical Center Lebanon, Pennsylvania

To: Office of Inspector General

Acting, Network Director, VISN 4

I have reviewed the findings within the report of the Combined Assessment Program Review of the VA Medical Center Lebanon, Pennsylvania. I am in agreement with the findings.

Corrective action plans have been established with planned completion dates, as detailed in the attached report.

TIMOTHY W. LIEZERT

Acting Director, Lebanon VA Medical Center

Acting Medical Center Director's Comments to Office of Inspector General's Report

The following Acting Director's comments are submitted in response to the recommendations and suggestions in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action(s) 1. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires: (a) contracting officers to initiate background investigations prior to contract performance and (b) contracting officers to ensure contract files contain all required documentation.

Concur **Target Completion Date:** December 1, 2003

(a) The Director of Contracting and the Information Security Officer (ISO) created a log to track background investigations. All new contracts are entered into the log. The log requires contracting officers to state when required background investigations were initiated. This forces the contracting officer to make sure the required clearances are complete. It also allows for review by the ISO. We now have two different sections checking to make sure the proper investigations are completed before performance.

After the IG visit, a meeting was held with all Acquisition Management Employees. ILO 90-01-06 was reviewed with particular emphasis on making sure background investigations were completed prior to contractor performance.

We are taking a pro-active approach with our affiliate. Sixty days before a new contract is issued, or an option is exercised, we are requesting a list of doctors that will be working under the affiliate contract. In doing this, we have plenty of time to determine who needs a background investigation and we can initiate the investigation well in advance of contract performance.

In addition, we are complying with the October 7, 2003 memorandum from the VISN 4 Director. This memorandum requires the contracting officer to certify that background checks have been initiated on all contractor employees who have access to sensitive information. This must be completed by December 1, 2003.

(b) The Lebanon VAMC created a Contract File Checklist for non-construction contracts. We have been using a Contract File Checklist for construction contracts for well over a year. However, the Construction Checklist didn't easily transfer to medical contracts. This new non-construction checklist will allow contracting to ensure all of the proper documentation is included such as workload analysis, price negotiation memorandums, and market research. Contracting obtained checklists from other VA Medical Centers to ensure we were creating a thorough checklist. The new Contract Checklist was completed by October 31, 2003.

Recommended Improvement Action(s) 2. We recommend that the Acting VISN Director requires that the Acting Medical Center Director ensure that conflict of interest issues are prevented on all contracts with the affiliate.

Concur **Target Completion Date:** October 1, 2003

All Lebanon VA Medical Center medical staff have been informed that a conflict of interest develops when they have an appointment with the affiliate, The Penn State College of Medicine at the Hershey Medical Center, and are requested to enter into the process of negotiating scarce medical service contracts with the affiliate. If issues arise involving the medical staff with the affiliate in the negotiating process, the Medical Center Director will follow established guidelines for seeking Regional Counsel advice on the issue.

Recommended Improvement Action(s) 3. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) FMS staff conducts a physical inventory of engineering supplies to obtain an accurate count of all items to be included in the GIP system, and (b) FMS managers implement GIP to monitor engineering supplies.

Concur **Target Completion Date:** December 30, 2003

(a) A physical inventory of engineering supplies is being completed. The physical inventory will manually list each different item in the engineering shops and include a physical count for input into GIP.

(b) Since the completion of the CAP, 553 items have been loaded into GIP. Items will continue to be loaded into the system. All actions to account for and manage the engineering items will be accomplished no later than December 30, 2003.

Recommended Improvement Action(s) 4. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) local policies include written procedures for the notification of the OIG Office of Investigations and the VA Police in the event of a controlled substances diversion, and local policies describe procedures for ordering and receiving controlled substances, and handling controlled substances prescriptions not picked up in the outpatient pharmacy at the close of the business day, (b) documentation of 72-hour inventories is maintained for two years, and (c) controlled substances held for destruction are inspected monthly using the proper inventory report.

Concur **Target Completion Date:** December 31, 2003

(a) The medical center's controlled substance policy (in draft at the time of the OIG site visit and reviewed by the OIG auditor during the facility survey) has been written to address the procedures for each of the items listed in this recommendation. The revised policy is in final rewrite and is expected to be signed by the Acting Director by the established target completion date. Staff education/training has been completed and the revised processes have been implemented.

(b) The two-year maintenance of documentation verifying 72-hour inventories was initiated in July 2003.

(c) Controlled substances held for destruction are inspected monthly utilizing the proper reporting tool as accessed through the appropriate computer menu options. Training was provided to the controlled substances pharmacy technicians to allow access to the report. The corrective actions for this recommendation were completed during September 2003.

Recommended Improvement Action(s) 5. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that annual fire and safety inspections of all CRC homes be completed.

Concur **Target Completion Date:** September 2003

Medical center safety staff are now completing annual fire and safety inspections of all homes included in the Community Residential Care program. This practice will continue until we are notified to proceed differently by Central Office staff.

OIG Suggestions

Suggested Improvement Action(s) 1. We suggest that the Acting VISN Director ensure that the Acting Medical Center Director requires that: (a) an alternate data processing facility be designated and added to the contingency plan and (b) IRM employees' access to the computer room is limited based on the level of employee need.

Concur **Target Completion Date:** January 1, 2004

(a) The Information Resource Management staff recognize this is a VISN-wide issue and not only a Lebanon VA Medical Center issue. Because of this, the concern is being addressed by VISN Information Technology staff in concert with the individual needs of the local facilities. Tentatively, Lebanon's alternate processing site will be the Coatesville VA Medical Center.

(b) The Chief Technical Officer recognized the need to diminish the number of staff with access to the computer room and has since reduced the number of staff with access to the area from 15 to 12.

Suggested Improvement Action(s) 2. We suggest that the Acting VISN Director ensure that the Acting Medical Center Director requires that part-time physicians obtain written supervisory approval in advance of working adjustable schedules.

Concur **Target Completion Date:** October 1, 2003

All Part-time physicians have been educated on and are monitored for adherence to their established fixed schedules. All Part-Time physicians are required to check in (in-person, by in-house telephone, or e-mail) with the Acute Care Timekeeper upon arrival and at departure from the medical center. Written verification of provider understanding of this requirement has been received. The Acute Care Timekeeper maintains a daily log of physician time spent on station in official capacity. The log is reviewed each pay period by the Acute Care Product Line Manager and reviewed with the physicians as appropriate.

Suggested Improvement Action(s) 3. We suggest that the Acting VISN Director ensure that the Acting Medical Center Director monitors the utilization of GPF accounts.

Concur **Target Completion Date:** September 30, 2003

All General Post Funds were reviewed and letters (e-mail) were sent to all approving officials listed for Fund Control Points that have been inactive for one year or more.

The General Post Fund Program Manager has initiated a spreadsheet to monitor this activity with the intention of identifying this issue on a more timely basis. The spreadsheet lists the last activity date and is updated monthly. The revised process includes sending letters of notification as soon as the Program Manager notices that the funds have remained on-hand in an inactive status for a period in excess of one year.

Suggested Improvement Action(s) 4. We suggest that the Acting VISN Director ensure that the Acting Medical Center Director requires the performance of internal reviews of PFOP accounts.

Concur **Target Completion Date:** December 15, 2003

The medical center has implemented a process/tracking system to have all required PFOP accounts evaluated every six months. The Manager, Health Administration Service will monitor this practice. Medical Center Leadership expects all accounts to be evaluated by December 15, 2003.

OIG Contact and Staff Acknowledgments

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Staff Acknowledgements	Maureen Barry John Cintolo Linda DeLong Dorothy Duncan James Lothrop Patricia McGauley Steven Rosenthal Virginia Solana

Appendix D

Report Distribution

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Non-VA Distribution

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