Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Northport VA Medical Center Northport, New York

Report No. 04-00403-128

April 14, 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 medical center staff.

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

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Executive Summary

Introduction

During the week of December 8–12, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Northport VA Medical Center which is part of Veterans Integrated Service Network (VISN) 3. 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 69 employees.

Results of Review

Patient care and QM activities reviewed were generally effective. While the medical center needed to include contractors, action was taken to streamline their process for conducting employee background investigations and fingerprinting. Laboratory security and information technology security were effective. The medical center's management of clinic waiting times and patient enrollment was adequate. Controls effectively ensured proper timekeeping for part-time physicians and helped avoid physician conflict of interest situations. Financial and administrative controls related to the Medical Care Collections Fund, undelivered orders, accrued services payable, general post funds, and personal funds of patients were also operating satisfactorily. To improve operations, VISN and medical center management needed to:

- Ensure that contract files contain required documentation and that background investigations are initiated for contract physicians and contract employees.
- Establish controls to strengthen accountability and effectively manage engineering and medical supply inventories.
- Strengthen controlled substances inspections and pharmacy security.
- Establish procedures to improve collections of delinquent accounts receivable for health services programs for active duty service members, retirees, and their families.
- Develop a more comprehensive recycling program to reduce waste disposal costs.
- Correct minor environment of care issues.
- Develop and benchmark provider-specific performance data for clinical reprivileging purposes.
- Ensure employees providing patient transportation services are properly screened and trained.

VISN 3 and Medical Center Directors' Comments

The VISN 3 and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–16, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This

report was prepared under the direction of Thomas L. Cargill, Jr., Director, and Jacqueline L. Stumbris, CAP Review Coordinator, Bedford Audit Operations Division.

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

Introduction

Medical Center Profile

Organization. The Northport VA Medical Center is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Plainview, Patchogue, and Westhampton, NY. In addition, the medical center operates seven mental health clinics in Nassau and Suffolk Counties, NY. The medical center is part of VISN 3 and serves a veteran population of about 220,000 in a primary service area that includes 2 counties in New York.

Workload. In Fiscal Year (FY) 2003, the medical center treated 38,176 unique patients, a 4 percent decrease from FY 2002. The decrease in unique patients occurred through attrition and because of a VA moratorium on veteran community outreach and the discontinuance of enrollment of Priority Group 8 veterans, since many of the veterans residing in the medical center's primary service area fall into this higher income group. Inpatient care, including Psychosocial Residential and Rehabilitation Treatment Program (PRRTP) workload, totaled 3,258 discharges, and the average daily census, including nursing home patients, was 260.4. The outpatient workload was 307,672 visits.

Resources. In FY 2003, the medical center's medical care expenditures totaled $173.6 million. The FY 2004 medical care budget is $179.1 million, 3 percent more than FY 2003 expenditures. FY 2003 staffing was 1,548 full-time equivalent employees (FTEE), including 95.8 physician and 304 nursing FTEE.

Programs. The medical center provides care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The medical center has 161 hospital beds, 170 nursing home beds, and 42 PRRTP beds.

Affiliations and Research. The medical center is affiliated with the State University of New York (SUNY) Medical School at Stony Brook and supports 122 medical resident positions in 11 training programs. In FY 2003, the medical center's research program had 103 projects and a budget of $2 million. Areas of research included cancer, lung disease, heart disease, hypertension, prostrate disorders, arthritis, and skin disease.

Objectives and Scope of the 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 medical center 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 requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and 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 or 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. The review covered medical center operations for FY 2003 and FY 2004 through December 12, 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:

Clinical Reprivileging
Clinic Waiting Times and Patient Enrollment
Controlled Substances Inspections and Pharmacy Security
Delinquent Accounts Receivable
Engineering and Medical Supply Inventories
Employee Background Investigations and Fingerprinting
Environment of Care
General Post Funds
Information Technology Security
Laboratory Security
Medical Care Collections Fund
Patient Transportation Services
Personal Funds of Patients
Physician Conflicts of Interest
Quality Management
Service Contracts
Timekeeping for Part-Time Physicians
Undelivered Orders and Accrued Services Payable
Waste Disposal and Recycling

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, 158 of whom responded. We also interviewed 31 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 two fraud and integrity awareness briefings. These briefings, attended by 69 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.

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

Employee Background Investigations and Fingerprinting Were Conducted In A Timely and Effective Manner. The medical center streamlined the process for conducting employee background investigations and fingerprinting. Before being issued identification badges, new employees must complete the Standard Form (SF) 85 "Questionnaire for Non-sensitive Positions" and be fingerprinted using a digital machine that is connected to a Federal Bureau of Investigation database. The medical center receives the results of the fingerprint searches within 72 hours. Our review of a report showing the status of background investigations and personnel files indicated the thoroughness of the process. To preclude a review of all personnel files, at our request the Chiefs of Human Resources Management Service and Police Service signed a joint certification stating that all employees had background investigations initiated or completed and had been fingerprinted.

Opportunities for Improvement

Service Contracts — Background Investigations Were Needed and Contract Documentation Needed Improvement

Condition Needing Improvement. Responsibility for contracting for the medical center is at the VISN Network Acquisition Program Office. A review of a judgment sample of 12 contracts valued at $4.6 million identified the following issues that required management attention:

- While oversight of employees improved, background investigations for 6 physician contractors to provide radiology and anesthesiology services and 11 individuals contracted to provide transcription services were initiated 3 to 13 months after contract performance began. Contracting officers are required to initiate background investigations of contractor personnel with access to VA computer systems and sensitive information prior to contract performance (three contracts valued at $1.7 million).

- Database searches of the Federal Government's Excluded Parties Listing System (EPLS) were not conducted to determine if prospective contractors were eligible for Federal contracts (nine contracts valued at $3.9 million).

- At the request of SUNY contracting officials, the VA contracting officer added 23 clauses, standard for all New York State contracts, to 2 contracts totaling $739,000, for anesthesia and radiology services. The VA contracting officer did not request VA Regional Counsel to review these 2 contracts to identify possible conflicts with Federal Government contracting requirements.

- The following required documentation was missing from the contract files reviewed:

  - Contracting Officer's Technical Representative (COTR) designation letters, which document COTR authority and monitoring responsibilities, were not prepared for eight contracts valued at $2.3 million.

  - Justifications to exercise option years were not documented for 10 contracts valued at $4.2 million. Contracting officers are required to consider past performance and continued need and to document justifications to exercise option years.

  - Price negotiation memoranda were not prepared for three contracts valued at $916,000. The price negotiation memorandum documents 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 process; and the contracting officials' determination that offered pricing was fair and reasonable.

  - Market research to determine the most suitable approach for acquiring services was not documented for two contracts valued at $794,000.

  - Abstracts of bids, listing all offers, were not prepared for two contracts valued at $994,000.

Recommended improvement Action 1. We recommended that the VISN Director ensure that VISN contracting officers take action to: (a) initiate background investigations of contractor employees prior to contract performance, (b) conduct database searches of EPLS prior to contract award, (c) obtain VA Regional Counsel guidance on state contract clauses, and (d) develop and utilize a checklist to ensure all required documentation is included in contract files.

The VISN Director agreed with the findings and recommendations and reported that a checklist had been added to every contract file detailing the need to process background investigations prior to contract performance, to query EPLS prior to contract performance, and to include required documentation for each contract. An internal board had been established to perform quarterly reviews of contract compliance. In addition, a procedure had been established advising contract specialists that guidance from the VA Regional Counsel must be obtained on state contract clauses. The improvement plans were acceptable, and we will follow up on the completion of planned actions.

Engineering and Medical Supply Inventories — Accuracy of Inventory Records Needed Improvement

Condition Needing Improvement. Medical center management needed to establish controls to strengthen accountability and effectively manage engineering and medical supply inventories. In FY 2003, the medical center spent $1,463,927 on engineering supplies and $1,890,708 on medical supplies, for a combined total of $3,354,635. The Veterans Health Administration's (VHA's) goal is to reduce supply inventories to 30-day levels. VHA requires medical facilities

to use VA's Generic Inventory Package (GIP) to establish proper inventory levels, set reorder quantities, and track supply usage. The following conditions required management attention:

Engineering Supplies

Engineering Service did not effectively implement GIP to manage the engineering supplies inventory. Personnel were not adequately trained to use GIP for ordering supplies, processing receipts, and tracking the use of supplies. This resulted in inaccurate GIP stock levels, turnover rates, and usage rates. To test the accuracy and reasonableness of inventory levels, we reviewed a judgment sample of 10 engineering supply items from the universe of 40 items in GIP. We compared the quantities on hand with the GIP November 2003 *Stock Status Report for Engineering*, and found that stock levels for 7 of the 10 items sampled were inaccurate. The quantities in GIP were overstated for six of the seven items and understated for the remaining item. This occurred because staff were not adequately trained to track receipts and withdrawals of supplies in the GIP database.

Medical Supplies

The Supply Processing and Distribution (SPD) Section did not effectively implement GIP to manage approximately 850 medical supply items. Although a wall-to-wall inventory was conducted in August 2003, GIP was not updated with the results and maintained thereafter because staff were not adequately trained to track receipts and withdrawals of supplies in the GIP database. In addition, bar coding and scanning procedures, which are critical for identifying items and amounts required for restocking, had not been implemented as required by VHA. According to the December 9, 2003, *Days of Stock on Hand Report*, the on-hand value of the SPD inventory was $324,536. A total of $253,000 (78 percent) appeared as excess inventory (greater than 30 days supply) in the report. To test the accuracy of the inventory valuation and quantities on hand, we reviewed a judgment sample of 10 medical supply items listed in the report. The quantities on hand and corresponding dollar values were incorrect for 8 of the 10 items. Quantities and dollar values were overstated for six of the eight items and understated for the remaining two items. SPD made the necessary corrections for these items during our review.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) conduct physical inventories of engineering and medical supplies listed in GIP and correct the information in the GIP database, (b) provide additional training to enable staff to better manage engineering and medical supplies inventories in the GIP database, and (c) conduct spot inventory checks to ensure GIP data is accurate and reliable.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that physical inventories of SPD and engineering supplies would be conducted and additional training would be provided to staff. Unannounced spot inspections of SPD and Engineering Service inventories will be conducted to ensure GIP data is accurate and reliable. In addition, one Inventory Management Specialist has been selected for SPD and one is being recruited for Engineering Service. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Controlled Substances Inspections and Pharmacy Security — Training, Pharmacy Security, and Medical Center Policy Needed Improvement

Condition Needing Improvement. Controlled substances inspector training, pharmacy security, and medical center policy needed improvement. The following conditions required management attention:

- During an OIG-observed unannounced controlled substances inspection, the inspector acknowledged she had not received the updated training on the new VHA handbook, *Inspection of Controlled Substances*.
- During our test of the Inpatient Pharmacy panic button, the VA Police went to the Outpatient Pharmacy as a result of unclear directions from the medical center dispatcher.
- Medical center policy did not include the requirement that the Director notify the OIG Office of Investigations of suspected diversions of controlled substances.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) controlled substances inspectors are retrained on the new VHA handbook, *Inspection of Controlled Substances*, (b) dispatchers receive additional training in emergency communications, and (c) local policy includes procedures for notifying the OIG Office of Investigations of suspected diversions of controlled substances.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that VHA web-based training had been initiated and that approximately 75 percent of inspectors had completed the course and received certification. The alarm message was modified so there could be no mistake in dispatching VA Police to a call from Pharmacy. Medical center policies were being revised and distribution scheduled for April 1, 2004. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Delinquent Accounts Receivable — Collection Efforts Needed Improvement

Condition Needing Improvement. Federal accounts receivable should be appropriately followed up for collection. These include the health services program for active duty service members, retirees, and their families known as TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Second and third computerized notices should be sent at 30-day intervals if payment is not received. If payment is not received after the third notice, a fourth notice is to be sent to the attention of the delinquent agency's Chief Financial Officer. There were a total of 1,746 TRICARE and CHAMPVA accounts receivable valued at $780,711 as of October 31, 2003. Approximately 500 (29 percent) of these debts, valued at about $204,000, were greater than 180 days old. A review of a judgment sample

of 20 accounts receivable showed that 14 had inadequate follow-up. Five of the 14 debts valued at $7,084 exceeded the 1-year claim filing time limit and were no longer collectible.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires improved follow up on TRICARE and CHAMPVA accounts receivable.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the medical center would establish a new service representing the Medical Care Collections Fund/Health Information Management section. This new service will absorb the management of TRICARE and CHAMPVA accounts receivable. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Waste Disposal and Recycling — Increasing Recycling Efforts Would Reduce Waste Disposal Costs

Condition Needing Improvement. In our review of the 12 service contracts discussed previously, we noted that Environmental Management Service (EMS) management had an opportunity to reduce waste disposal costs by increasing recycling efforts.

The medical center paid $250,400 annually to dispose of waste material. Although cardboard, paper, and commingled metal were recycled, EMS staff did not recycle glass, plastic, wood, textiles, or construction debris. Under the terms of the contract, the medical center was not charged for the removal of recyclable materials and the contractor was allowed to retain any revenues received from the recycled material. By increasing recycling efforts, the medical center could reduce the volume of waste taken to the landfill, thereby reducing disposal costs. For example, eliminating the weekly pickup of just one 30 cubic yard container of waste material would save $17,940 per year ($345 per pickup x 52 weeks).

Additionally, waste disposal costs could be further reduced if the medical center separated commingled metals into ferrous (steel, cast iron, and tin) and nonferrous metals (aluminum, brass, copper, and lead). Based on price quotes from a local recycling company and the amount of recyclable material generated from December 2002 to December 2003, the medical center could have saved between $8,000 and $30,000 by separating more materials for recycling.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Medical Center Director develops a more comprehensive recycling program to reduce waste disposal costs.

The VISN and Medical Center Directors agreed with the suggestion and reported that the medical center had entered into negotiations with the contractor to increase recycling efforts. The improvement plans were acceptable, and we consider this issue resolved.

Environment of Care — Minor Environment of Care Deficiencies Needed Correction

Condition Needing Improvement. We inspected all medical center clinical areas and found the environment of care to be generally acceptable. However, we found minor problems such as prescription pads left unsecured in clinical offices and cleanliness issues. There were broken or dirty gaskets on both laboratory refrigerators and refrigerators storing patient food. Medical Inpatient Unit 33 and the inpatient and outpatient pharmacies needed cleaning. While we were onsite, managers took immediate steps to correct most of these deficiencies, and the Medical Center Director submitted an action plan to address the unresolved issues.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director implements the action plan for correcting unresolved environment of care issues.

The VISN and Medical Center Directors agreed with the suggestion and reported that the action plan for correcting unresolved environment of care issues had been implemented. For example, random inspections will be conducted to determine that prescription pads are secure, and additional housekeeping staff will be added to improve cleanliness. The improvement plans were acceptable, and we consider this issue resolved.

Clinical Reprivileging — Provider Specific Performance Data Needed To Be Developed and Benchmarked

Condition Needing Improvement. VHA requires that clinical reprivileging includes an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on provider-specific performance improvement elements or benchmarks. Reprivileging is the process of renewing the privileges of a practitioner who currently holds privileges within the medical center. We reviewed minutes of the Credentialing and Privileging (C&P) Committee and the C&P files of seven physicians from seven medical and surgical specialties. The C&P files did not include adequate information to effectively evaluate the individuals' performance. Four of the seven files did not include a record of medical/surgical complication rates and none of the files contained benchmark provider-specific performance data for reprivileging.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Medical Center Director requires that clinical service chiefs develop and benchmark provider-specific performance data for reprivileging.

The VISN and Medical Center Directors agreed with the suggestion and reported that the Chief of Staff had established a list of benchmark data sets that are to be used for provider reprivileging. Monitoring of this activity will be coordinated through the Performance Improvement Office. The improvement plans were acceptable, and we consider this issue resolved.

Patient Transportation Services — Employees Transporting Patients Needed To Be Screened and Trained

Condition Needing Improvement. We reviewed local policies and interviewed medical center managers to evaluate the safety and effectiveness of patient transportation services. We found that the two nursing assistants assigned to provide transportation services needed initial driver screening and training. VA regulations require that supervisors responsible for employees who transport patients ensure that drivers receive physical examinations, possess valid state drivers' licenses, maintain safe driving records, and receive driver safety training. These components of driver screening should be accomplished at a minimum of every 4 years. We reviewed training records, Official Personnel Folders, and employee health records for the two medical center employee drivers. Physical examinations, verification of driving records, and driver safety training had not been performed. The Associate Director of Patient Care Services stated that patient transportation was considered a collateral duty for the nursing assistants and was not documented in the position descriptions or performance evaluations of these employees as required by VA policy.

Suggested Improvement Action 4. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) employees who perform patient transportation services are properly screened and trained, (b) documentation of training is maintained, and (c) collateral transportation duties are documented in employee position descriptions and performance evaluations.

The VISN and Medical Center Directors agreed with the suggestions and reported that VA Police Service would verify drivers' licenses and driving records of employees who perform patient transportation services. Employee Health Service will provide physical examinations for these employees every 4 years, all staff transporting patients will receive proper training, and the training documentation will be maintained. The transportation duties have been added to the Title 5 employees' position descriptions and Title 38 employees' functional statements. The improvement plans were acceptable, and we consider this issue resolved.

Appendix A

VISN 3 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2004

From: VISN 3 Director

Subject: **Northport VA Medical Center Northport, New York**

To: Inspector General

Attached please find the draft response to the Office of Inspector General Combined Assessment Program Draft report of the Northport VAMC, Project # 2004-00403-RI-0247. The VISN concurs with the action plan submitted by the medical center.

/s/
James J. Farsetta

Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2004

From: Medical Center Director

Subject: **Northport VA Medical Center Northport, New York**

To: Inspector General

This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program Draft Review of the Northport VAMC- Project Number 2004-00403-R1-0247.

Northport VAMC provides high quality healthcare to our nation's veterans. This was evident to the OIG Investigators. Thank you for the opportunity to comment on the recommendations for improvement contained in this report.

If you have any questions or concerns, please contact me at 631-754-7960

/s/
ROBERT S. SCHUSTER, MHCA

Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that VISN contracting officers take action to: (a) initiate background investigations of contractor employees prior to contract performance, (b) conduct database searches of EPLS prior to contract award, (c) obtain Regional Counsel guidance on state contract clauses, and (d) develop and utilize a checklist to ensure all required documentation is included in the contract files.

Concur **Target Completion Date:** On-going

a) A checklist has been added to every contract file specifically detailing the need to process background investigations prior to contract performance. The contract specialist responsible for the contract will ensure this item is in the contract folder. In addition, an internal board within the Acquisition Program has been established that will be responsible for checking contracts for compliance on a quarterly basis. All findings and corrective action will be documented.

b) A checklist has been added to every contract file specifically detailing the need to conduct a database search of EPLS prior to contract performance. The contract specialist responsible for the contract will ensure this item is in the contract folder. In addition an internal board within the Acquisition Program has been established that will be responsible for checking contracts for compliance on a quarterly basis. All findings and corrective action will be documented.

c) A Standard Operating procedure (SOP) has been established advising contract specialists that guidance from Regional Counsel must be obtained on state contract clauses. Contract Specialists have signed and accepted the guidelines set forth in the SOP. A copy of the sign-in sheet is maintained in the Head Contracting Authority's Office.

d) A checklist has been added to every contract file specifically detailing the item required for each contract. The contract specialist responsible for the contract will ensure each item is present and reflected on the checklist. In addition, an internal board within the Acquisition Program has been established that will be responsible for checking contracts for compliance on a quarterly basis. All findings and corrective action will be documented.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) conduct physical inventories of engineering and medical supplies listed in GIP and correct the information in the database, (b) provide additional training to enable staff to better manage engineering and medical supplies inventories in the GIP database, and (c) conduct spot inventory checks to ensure GIP data is accurate and reliable.

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

Prior to the CAP audit, Northport VAMC began the recruitment process for two Inventory Management Specialists. One has been selected for SPD, one is being recruited for Engineering Service.

The following actions will occur by the target date.

a) New physical inventories within SPD and Engineering

b) Additional training - Two lead Inventory Management Specialists and two Nursing SPD Managers will be visiting Murfreesboro VAMC in Tennessee the week of 2/22/04 to view their program, as recommended by the Chief, Material Management, Central Office. The Supply Manager Specialist for VISN 3, a member of the National Training Team, will come to Northport and provide training for the Inventory Management Specialists, SPD management, Engineering management and distribution staff.

c) Spot inventory checks will be conducted to ensure GIP data is accurate and reliable. A third party will conduct unannounced spot inspections of SPD and Engineering inventories.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) controlled substances inspectors are retrained on the new VHA Handbook, *Inspection of Controlled Substances*, (b) dispatchers receive additional training in emergency communication, and (c) local policy includes procedures for notifying the OIG Office of Investigations of suspected diversions of controlled substances.

Concur **Target Completion Date:** April 2004

a) To ensure controlled substances inspections are properly conducted, the mandated VHA web-based training has been initiated and approximately 75% of inspectors have completed the course and received certification. The draft policy which includes references and procedures outlined in the August 2003 VHA Handbook, *Inspection of Controlled Substances*, has been completed and forwarded to Service Chiefs/Union for concurrence. The proposed date for distribution of the new policy is April 1, 2004.

b) In December 2003, the alarm message on the computer was modified so there could be no mistake in dispatching the Police to a call from Pharmacy. The two locations are now clearly identified so a mistake of this nature should not be repeated.

c) Local policy has been revised to include procedures for notifying the OIG Office of Investigations in the event of a suspected diversion of controlled substances. The draft policy that includes this reference has been completed and forwarded to Service Chiefs/Unions for concurrence. Distribution is set for April 1, 2004.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires improved follow up on TRICARE and CHAMPVA accounts receivable.

Concur **Target Completion Date:** April 2004

To provide better and timelier collection efforts, prevent loss of revenue, and avoid any potential conflict of interest, the Northport VAMC will establish a new service representing the Medical Care Collections Fund/Health Information Management section, consistent with the current centralized Business Office configuration being proposed by VHA. This new service will absorb the management of TRICARE and CHAMPVA accounts receivable.

OIG Suggestions

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the Medical Center Director develops a more comprehensive recycling program to reduce waste disposal costs.

Concur **Target Completion Date:** July 2004

The Medical Center is developing a more comprehensive recycling program to reduce waste disposal costs. The Medical Center has entered into negotiations with the contractor, National Waste Services, to improve the recycling program to include glass, plastic, wood, textiles, and construction debris. Revenue generation is being explored commensurate with this action.

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the Medical Center Director implements the action plan for correcting unresolved environment of care issues.

Concur **Target Completion Date:** Ongoing

The Medical Center Director's plan of action for correcting unresolved environment of care issues has been implemented. Following are examples of implementation.

Medical Center policy has been revised to include the following: "The individual provider is responsible for the security of his/her prescription pad." Quarterly, each clinic will be randomly inspected to determine that prescription pads are secure. Findings will be submitted to Performance Improvement, and reviewed at Morning Meeting with the Chief of Staff and Director. Action is completed.

Refrigerator gaskets will be checked medical center wide and replaced as indicated. Target Date: April 2004.

Four individuals have been selected for Environmental Management Service positions. Their starting dates are pending, and recruitment is also pending for 3 additional positions. The increase in housekeeping staff will alleviate the problem of cleanliness on the inpatient units and in the pharmacy. Action is Ongoing.

Suggested Improvement Action 3. We suggest that the VISN Director ensure that the Medical Center Director requires that clinical service chiefs develop and benchmark provider-specific performance data for reprivileging purposes.

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

The Chief of Staff established at the January 2004 Clinical Executive Board meeting, that some combination of the following data sets must be included in the provider file for reprivileging purposes based on medical specialty:

Performance measures (National benchmark)

National Surgical Quality Improvement Program data (National benchmark)

Peer Reviews

Autopsy rates (National benchmark)

Medical Record Completion rates (JCAHO standard)

Length of stay/Utilization Review data (National benchmark)

Residency Supervision compliance

Blood utilization (Local benchmark)

Armed Forces Institute of Pathology (National Pathology benchmark)

Relative Value Units (primarily utilized by Imaging services)

The documentation and review of this data will be available in both Vet Pro (a Federal computerized package for credentialing and privileging information) and the minutes of the Credentialing and Privileging Committee. Monitoring of this documentation and review will be coordinated through the Performance Improvement Office and reported to the Director through the Clinical Executive Board on a quarterly basis.

Suggested Improvement Action 4. We suggest that the VISN Director ensure that the Medical Center Director requires that: (a) employees who perform patient transportation services are properly screened and trained, (b) documentation of training is maintained, and (c) collateral transportation duties are documented in employee position descriptions and performance evaluations.

Concur **Target Completion Date:** February 2004

a) Employees who perform patient transportation are properly screened and trained according to VA regulations. The medical center currently maintains a spreadsheet of all employees' valid state drivers license numbers. VA Police will verify drivers' licenses and driving records as of February 2004. All employees transporting patients will receive a physical examination every four years by Employee Health Service. All staff transporting patients will receive proper initial and recertification training as outlined in our policy.

b) Documentation of training will be maintained in the TEMPO computerized system.

c) The collateral transportation duties are documented in the employee' position description and performance evaluation. - The collateral duties have been added to the employees' position descriptions and functional statements as appropriate.

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

Report Distribution

VA Distribution

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Director, Northport VA Medical Center

Non-VA Distribution

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- Steve Israel
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