Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center Saginaw, Michigan

Report No. 03-03038-168

July 15, 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.
- 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.

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 the CAP Review 1

Results of Review 4

Organizational Strengths 4

Opportunities for Improvement 5

Patient Transportation Services 5

Environment of Care 7

Management of Keys 10

Controlled Substances Accountability 12

Supply Inventory Management 13

Pharmaceutical Cache Program 15

Agent Cashier 16

Accounts Receivable 17

Information Technology Security 18

Contract Management 19

Appendices

VISN Director Comments 21

Monetary Benefits in Accordance with IG Act Amendments 32

OIG Contact and Staff Acknowledgments 33

Report Distribution 34

Executive Summary

Introduction

During the week of December 1 – 5, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Aleda E. Lutz VA Medical Center (referred to as the medical center). The purpose of the review was to evaluate selected 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 85 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

This CAP review focused on 15 areas. As indicated below there were no concerns identified in five of the areas. The remaining 10 areas resulted in recommendations or suggestions for improvement.

The medical center complied with selected standards in the following areas:

- Information Technology (IT) Purchases
- Medical Care Collections Fund (MCCF)
- Part-Time Physicians' Time and Attendance
- QM
- Unliquidated Obligations

Based on our review of these five areas, the following organizational strengths were identified:

- An effective QM program
- Satisfactory monitoring of part-time physicians' time and attendance
- Appropriate management of the MCCF
- Effectively controlled IT purchases

We identified 10 areas which needed additional management attention. To improve operations, the following recommendations were made:

- Strengthen internal controls for patient transportation services.
- Correct safety and environmental deficiencies.
- Strengthen controls over medical center keys.
- Report suspicious losses of controlled substances to the OIG and strengthen controls over controlled substances.
- Reduce supply stock levels and improve inventory management controls.

Suggestions for improvement were made in the following areas:

- Improve Pharmaceutical Cache Program policies and controls.
- Improve Agent Cashier unannounced audit procedures.
- Improve controls over accounts receivable and more aggressively pursue collections.
- Enhance controls over information technology security.
- Improve contract administration and file documentation.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, Chicago Regional Office of Healthcare Inspections, and Ms. Katherine Owens, CAP Review Coordinator, Chicago Regional Office of Healthcare Inspections.

VISN 11 Director Comments

The Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 20 for the full text of the Director's comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Saginaw, Michigan, the Aleda E. Lutz VA Medical Center consists of an acute care hospital, an intermediate care facility (ICF), and ambulatory care clinics located on the main campus. Community-based outpatient clinics (CBOCs) are located in Gaylord, Oscoda, and Traverse City, Michigan. The medical center serves as a primary service area for 36 counties in Michigan's lower peninsula.

Programs. The medical center provides comprehensive primary, medical, geriatric, ambulatory surgical, and mental health services. It has 33 acute care medicine beds and 81 beds dedicated to the ICF. The medical center also offers physical medicine and rehabilitation, hematology/oncology, cardiology, pulmonary, podiatry, endocrinology, urology, infectious disease, neurology, nephrology, peripheral vascular, dentistry, optometry and ophthalmology services. A sharing agreement exists with the U.S. Naval Office of Medical/Dental Affairs.

Affiliations and Research. The medical center is affiliated with Synergy Medical Education Alliance (previously Saginaw Cooperative Hospitals, Inc.) through the Michigan State University College of Human Medicine. The medical center supports 18 residents approved for training each year. Additionally, the medical center has affiliations with 10 area universities and colleges supporting training in nursing, dietetics, optometry, pharmacy, physical therapy assistant, physician assistant, social work, and sonography. The medical center does not have a research program.

Resources. The budget for Fiscal Year (FY) 2002 totaled approximately $59 million and the FY 2003 budget totaled approximately $66 million. The FY 2002 staffing was 508 full-time employee equivalents (FTEE) and the FY 2003 staffing was 546 FTEE, which included 28 physician and 160 nursing FTEE.

Workload. The medical center treated 21,171 unique patients in FY 2002 and 22,434 unique patients in FY 2003. Inpatient workload totaled 1,341 discharges in FY 2002 and 1,230 discharges in FY 2003. The average daily bed census for FY 2003 was 17 for acute care and 67 for the ICF. The outpatient workload totaled 151,264 visits for FY 2002 and 165,208 visits for FY 2003.

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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts Receivable	Medical Care Collections Fund
Agent Cashier	Part-Time Physicians' Time and Attendance
Contract Management	
Controlled Substances Accountability	Patient Transportation Services
Environment of Care	Pharmaceutical Cache Program
Information Technology Purchases	Quality Management
Information Technology Security	Supply Inventory Management
Management of Keys	Unliquidated Obligations

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees who had Internet access and 49 responded. We also interviewed 30 patients during the review. The surveys indicated high levels of employee and patient satisfaction and did not disclose any significant issues. The survey results were shared with the medical center managers.

During the review, we also presented four fraud and integrity awareness training sessions for employees. Eighty-five employees attended these sessions, 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 facility operations for FY 2002 and FY 2003 through November 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strengths

The Quality Management Program was Effective. The medical center had an effective QM program to monitor and improve the quality of care by using national and local performance measures and patient safety management strategies. Provider-specific data was gathered, organized, and analyzed for the purpose of granting clinical privileges to providers. Documentation in the providers' individual clinical privileges files showed that corrective actions for identified deficiencies were monitored until resolved. Management demonstrated their support for the QM program through active participation in QM committees and by providing the necessary resources to accomplish performance improvement initiatives.

Part-Time Physicians' Time and Attendance Was Satisfactorily Monitored. The medical center employed five part-time physicians. These physicians signed attendance records, and timekeepers documented their attendance. Fiscal Service employees audited timekeepers' records twice a year, provided timekeeper training annually, and initiated appropriate corrections as warranted.

The Medical Care Collections Fund Was Appropriately Managed. Medical center employees appropriately managed the MCCF and accurately coded and identified billable procedures. Billings were timely processed, and collections of accounts receivable were actively pursued.

Information Technology Purchases Were Effectively Controlled. Medical center employees obtained proper approvals, paid reasonable prices, and used contracted sources for IT equipment and software purchases.

Opportunities for Improvement

Patient Transportation Services – Internal Controls Needed Strengthening

Condition Needing Improvement. Managers needed to ensure that: driving records for employee motor vehicle operators (MVOs) and volunteer drivers are reviewed for violations, convictions, or other abuses; volunteer drivers are appropriately screened; and annual safe driving training is completed by all individuals who transport patients. Additionally, managers needed to ensure that contract drivers' competency records are annually reviewed. To improve patient safety during transports, managers needed to ensure that outpatients scheduled for transport are appropriately assessed to determine the need for employee escort, significant patient events occurring during transports are reported to clinical employees and documented in the patients' medical records, and options to minimize the duration of trips for patients on stretchers are explored.

Driving Record Verifications. Federal regulations require that managers responsible for MVOs and volunteer drivers ensure that driving records are reviewed prior to candidates' appointments as drivers and every 4 years thereafter. We interviewed the MVO supervisor; the Chief, Voluntary Service; Human Resources managers and employees. We also reviewed three MVOs' Official Personnel Folders and three volunteers' files. Two of the three MVOs in our sample had been in their positions for at least 5 years, and two of the three volunteer drivers held their positions for over 14 years. Documentation did not support that initial and follow-up reviews of MVOs' or volunteers' driving records were accomplished.

Volunteer Drivers. Federal and VA regulations require that volunteer drivers receive physical examinations and have their personal insurance coverage verified prior to their appointments as drivers. The Chief, Voluntary Service told us that the volunteer drivers received initial physical examinations. However, documentation in the three files we reviewed did not support this statement. The Chief, Voluntary Service was establishing a process to ensure that volunteer drivers received annual physical examinations. Additionally, documentation in the files did not support that personal insurance coverage for the drivers was verified initially and every 4 years thereafter.

Safe Driving Training. VA regulations require that facilities develop and implement a Motor Vehicle Safety Program when vehicles are operated for official business. Facilities are required to present at least one formal safe driving training program annually for all individuals who transport patients. We reviewed training records for the same MVOs and volunteer drivers discussed above, and found that documentation did not support that annual safe driving training was accomplished for the individuals.

Contract Driver Competency. We reviewed a service contract that the medical center had established with a community transport vendor. The contract requires the vendor to annually submit a written report attesting that drivers have current and appropriate driver licenses. Documentation must also show that all ambulance drivers maintain current basic cardiac life support certification and that all skilled life support drivers maintain current advanced cardiac life support certification. While we found documentation in the contract file regarding the employees' licenses, we did not find additional documentation to support that their competencies were maintained.

Patient Assessment and Event Reporting. Patients require appropriate supervision during transport, based on assessments of their physical and mental status, to ensure patient and driver safety. Managers allowed outpatients to make their own arrangements for transport with a Travel Office employee without being clinically assessed to determine their need for an employee escort. MVOs told us they frequently encountered patient events that ranged from searching for missing patients to managing illnesses and behavioral problems. They also told us that information about significant events was not communicated to clinical employees and, therefore, was not documented in patients' medical records for consideration of future scheduled transports.

Transport of Patients on Stretchers. Patients who need to be transported on stretchers and require specialty care appointments are transported from the medical center to VA medical facilities in Detroit and Ann Arbor (both over 85 miles away). MVOs told us that patients were transported concurrently with scheduled ambulatory patients, which required patients on stretchers to depart the medical center early in the morning and remain at the visiting facility until all the patients had completed their appointments late in the afternoon. Additionally, there were occasions when drivers transported patients to both Detroit and Ann Arbor VA medical facilities on the same day, requiring the patients to be on stretchers for 10 hours or longer.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) review driving records of MVOs and volunteer drivers for violations, convictions, and other abuses; (b) ensure physical examinations and verifications of personal insurance are accomplished for volunteer drivers; (c) require that all individuals who transport patients receive annual safe driving training, and training is documented; (d) ensure that the contract transport vendor annually submits the required documentation regarding drivers' competencies; (e) ensure that patients scheduled for transport are assessed for escort needs, and procedures are developed to report to clinical employees and document in medical records significant patient events that occur during transport; and (f) explore options to minimize travel time for patients required to travel on stretchers.

The VISN Director and the Medical Center Director agreed with the findings and recommendations. Employee MVOs have been assessed for current drivers' licenses, and reviews of driving records have been completed. Driving record reviews, physical

examinations, and insurance verifications have been accomplished for volunteer drivers. MVOs are completing training on safe/defensive driving, and volunteer driving training will be accomplished. Patients are being screened to determine the need for attendants, and documentation of significant events is being placed into the patients' medical records. Patients traveling by stretcher are given priority for appointments at tertiary care sites. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Environment of Care – Safety and Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. Managers needed to ensure that patient care areas are safe and appropriately maintained, patient privacy is protected, biohazardous storage rooms are secured, and employees are aware of evacuation plans in their work areas. Veterans Health Administration (VHA) regulations require that the patient care environment present minimal risk to patients, employees, and visitors. Additionally, managers needed to ensure that Veterans Canteen Service (VCS) food service employees follow infection control procedures, and that the canteen is cleaned and maintained according to VCS standards.

Patient Safety. During our inspection of the Ambulatory Procedure Unit/Operating Room (APU/OR), we requested a locked door be opened. We observed exposed cinderblock walls and a ceiling opening to the interstitial area. The walls and ceiling opening were partially draped by plastic sheathing. We felt strong air currents blowing from the exposed areas. When we informed managers of this potential source of contamination to the APU/OR areas, we were told that they had no knowledge of construction in the area. Construction areas need to be secured to contain dust and debris and to protect patients, visitors, and employees.

We found an unsecured exit door in the ICF that opened to stairs and a loading dock. The Director, Geriatrics and Extended Care told us that employees use the door to enter and exit their work areas. The door was equipped with a WanderGuard®[1] system that locked the door when a patient with a WanderGuard® monitoring device approached the door. However, patients who are not required to wear a WanderGuard® device were able to exit through the door unimpeded. These patients were at risk of falling from the loading dock or down the stairs. To improve patient safety, the exit door should be secured.

In hallways throughout the facility, we found damaged or missing corners on handrails and bumper guards. Many of these handrails and bumper guards had exposed sharp

[1] The WanderGuard® is an audible alarm system used to notify employees when a patient, assessed at risk of wandering, is about to exit an inpatient unit.

metal supports protruding from the openings, presenting a safety hazard to patients, visitors, and employees.

ICF patients and nurses reported that responses to emergency call lights were sometimes delayed during the evening and night tours of duty when staffing is reduced and clerical support employees are not on duty at the nurses' station. Nurses told us that when patients pull the emergency cords located in their bathrooms, lights flash and an alarm sounds at the nurses' station. However, when nursing employees are away from the nurses' station assisting other patients, they are unable to see the lights or immediately hear the alarms. This condition could result in patients waiting several minutes before an employee responds to the call light and delaying needed care.

Patient Privacy. One room in the APU/OR was used for multiple patient care activities ranging from preparing patients for procedures and performing procedures (such as chemotherapy and bone marrow aspirations) to post-procedure recovery and medical record documentation. This crowded multipurpose room did not ensure patient privacy or the security of patient information as required by Federal law. Curtains were used between patients; however, we were told by nursing employees that sometimes patients requested that the curtains be left open because they felt claustrophobic. Computer monitors were also positioned so that patients, visitors, and other employees could read sensitive information.

Biohazardous Storage Room Security. On the medical unit, we found an unsecured door with a sign identifying the room as a storage area for biohazardous materials. We observed in the room a biohazardous container, a soiled utility sink, and a mop and bucket used by nursing employees to clean spills. Since the room was used for storage of biohazardous materials, the door must be secured to prevent access by unauthorized persons.

Fire Safety. We inspected the medical unit and an ICF unit and noted that fire evacuation routes were posted and alarms were located on walls of the units, and nurse managers told us that fire drills were conducted monthly on each shift. However, four employees from the medical unit and three employees from the ICF unit were unable to describe fire evacuation procedures. Employees must be able to demonstrate their understanding of evacuation procedures in the event of an emergency.

VCS Infection Control. Our inspection of the VCS food preparation area revealed that a double sink was used for both thawing raw meats and preparing salads. VCS standards require that when a separate area is not available for each task, sinks need to be cleaned and sanitized between uses. VCS managers and employees could not describe sanitation procedures required to ensure that sinks were properly cleaned to prevent cross-contamination. We also found an increased risk for contamination of ice used in the canteen. The icemaker did not have handles installed to open the lid; consequently, employees had to place their hands directly on and inside the lid to open it. VCS

managers told us that the need for handles was identified during a medical center environment of care inspection 2 weeks prior to our CAP review and that a work order for installation had been submitted. Additionally, we found an ice scoop on top of an adjacent cabinet. The ice scoop should be sanitized at the beginning and end of the workday, and as needed during the day, and stored in a clean, dry container.

Additionally, we observed an uncovered trash container that was routinely stored beside a freight elevator, which is also adjacent to a pharmacy waiting room. A Facilities Management Service (FMS) employee told us that the container was used to collect trash and garbage from VCS areas. According to VCS standards, garbage containers should be kept covered when not in use.

VCS Cleaning and Maintenance. We found that the vent hood and lights in the cooking area behind the serving line were soiled with accumulated grease and dirt. The walls and floors in this area, especially behind the cooking equipment, had an accumulation of grease; and debris was present along the baseboards. According to VCS standards, vent hoods should be degreased monthly and serviced biannually by the manufacturer. We were unable to determine the date of the most recent service because the service record attached to the hood was illegible, and the VCS manager was unable to provide us with the last date of service. In the VCS kitchen, we found accumulated debris and trash on the floors, under and behind equipment, and on horizontal equipment surfaces. We found that handles and vertical surfaces of freezers and refrigerators were soiled. Frequent cleaning is required to keep these surfaces clean and sanitary.

There was an outside window, in the kitchen, with a wooden frame that had peeling and chipped paint and appeared rotted. The window was between two large pieces of cooking equipment. Adjacent to the window, we found broken and missing wall tiles. Repair or replacement of this window frame is needed, and broken and missing tiles should be replaced. We also found that the ceiling and exposed pipes in the dry storage area had dried residue on their surfaces. Storage areas needed to be maintained in the same sanitary condition as required in the cooking and serving areas.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) patient safety and maintenance deficiencies are corrected; (b) patient privacy is protected in the APU/OR; (c) biohazardous storage rooms are secured; (d) employees are trained and able to describe emergency evacuation procedures; (e) VCS employees practice proper infection control procedures; and (f) routine cleaning and maintenance of the VCS is accomplished according to VCS standards.

The VISN Director and the Medical Center Director agreed with the findings and recommendations. Patient safety and maintenance deficiencies were corrected, and privacy issues in the APU/OR were addressed. The storage room was reevaluated and determined not to be for biohazardous storage. Emergency evacuation procedures were

evaluated, and employee training was completed. VCS employees received training on proper infection control procedures, a Medical Center Memorandum was established to describe cleaning and maintenance expectations, and recommended cleaning and repairs of the VCS were completed. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Management of Keys – Controls Needed Strengthening

Condition Needing Improvement. Managers needed to improve medical center key accountability and ensure that keys are appropriately distributed.

Key Accountability. The medical center key control policy requires that the key control system contributes to a recorded chain of accountability for each room and area key issued by FMS to key users, through the users' service chiefs. During the preparation phase of the CAP review, we reviewed a medical center report that referenced a lack of control over medical center keys. Therefore, we performed a review of control, accountability, and distribution of keys.

Grand Master Keys. Grand master keys operate most lock systems within the medical center, including exterior doors, the Director's office, QM offices, medical information and patient records areas, most service offices, and the ambulatory surgery suite medication room.[2] According to medical center policy, grand master keys are authorized for the Medical Center Director; Chief of Staff; Associate Director for Patient Care Services; Chief, FMS; Chief, Police Service (two keys); Chief, Patient Administration Service; Assistant Chief, FMS; Maintenance Supervisor; Housekeeping Aid Supervisor; and Safety Manager. According to documentation, 18 grand master keys had been made and distributed. Of these 18, 4 could not be accounted for, including 1 that had not been turned in by a contractor, and 1 that had not been turned in by a former employee. Additionally, we also found that the contractor was not approved to have a grand master key, and there was no certification showing the need for this key. The medical center locksmith could not produce documentation that showed the disposition of the remaining two keys.

Of the 14 keys that we could account for, 10 had been issued to employees in accordance with medical center policy, and 1 was issued to the Executive Management Officer who was not approved to receive it. Of the remaining three keys, one was unassigned and in the possession of the medical center locksmith, and two had been destroyed.

Service Master Keys. Service master keys operate a portion of locks within a system of locks. For example, FMS employees used service master keys to enter electrical closets, generator rooms, and other service areas. Documentation showed that 150 service master

[2] Grand master keys did not open Pharmacy Service space, narcotics vaults, Information Resource Management (IRM) Service space, or the locksmith shop.

keys had been made. In order to maintain effective physical security, deter crime, safeguard valuable equipment, vehicles, records, funds, drugs, and supplies, and to protect patients and their belongings, medical center policy requires that keys be issued to VA employees only upon certification of need by service chiefs or a higher authority. At the time of our review, 97 of the 150 keys had been issued to employees without the required certifications, 29 keys had been returned to the medical center locksmith, and 24 keys were unaccounted for.

Sub-Master Keys. Sub-master keys operate locks within a particular service zone and access offices, storage rooms, and other rooms within an area. Twenty sub-master keys for the APU/OR area, which included a medication room, were issued to employees without the required certifications of need.

Special Keys. There were eight keys issued to employee union representatives who needed them to access assigned union space. However, these same keys also operated locks in an area called the Primary Care Red Team. This clinic space included a medication room. The medical center locksmith believed that union representatives did not know that their keys opened the Primary Care Red Team area and its medication room. In addition, seven identical keys were issued to clinic employees for use in the Primary Care Red Team area itself. However, there was no documentation to indicate which employees received the keys or that service chiefs had certified an official need for the keys.

Summary. Weak accountability, controls, and the issuance of keys to unapproved individuals compromised the overall security of the medical center. The Chiefs of FMS and Police Service agreed with this assessment. The Chief, FMS stated that the medical center planned to realign locksmith operations from FMS to the Police Service. In addition, medical center management had a proposal to re-key the entire facility at an estimated cost of $28,382. The Chief, FMS also stated that medical center management had long-range plans to convert to an electronic key system that would track employees' access to all areas of the facility. The Medical Center Director estimated that the cost of the electronic key system would be approximately $1 million.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish and implement accountability procedures for medical center keys and distribute keys only to employees who have certifications of need by service chiefs or a higher authority; and (b) re-key vulnerable areas, such as medication rooms, and implement plans to re-key remaining locks or convert to an electronic key system.

The VISN Director and the Medical Center Director agreed with the findings and recommendations. An environmental security risk assessment was completed, and Police Service will now oversee the key control program. The medical center is being re-cored/re-keyed, and it is expected that all exterior and interior doors will be completed by

August 31, 2004. Security in high-risk areas, such as medication rooms, has been improved. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Controlled Substances Accountability – Suspicious Losses Needed To Be Reported and Other Controls Strengthened

Condition Needing Improvement. Pharmacy Service employees conducted required 72-hour and biennial inventories. Controlled substances inspection procedures were adequate, and inspectors were properly trained. However, medical center managers needed to notify the OIG when suspicious losses of controlled substances occur. Pharmacy Service employees needed to account for returned controlled substances and issue only full prescription pads. Additionally, Police Service employees needed to notify Pharmacy Service managers of deficiencies identified by annual physical security inspections so that corrective actions could be taken.

Suspicious Losses. VA regulations and medical center policy require medical center managers to report suspected thefts, diversions, or other suspicious losses of controlled substances to the OIG. From January 10 to December 5, 2003, medical center managers investigated several reported incidents of missing controlled substances by initiating two fact-finding reviews and convening two boards of investigations (BOIs).[3] For example, a BOI conducted in January 2003 investigated the loss of 120 hydrocodone tablets, a frequently abused controlled substance, and found an apparent pattern of controlled substances losses on one inpatient unit that occurred between June 2002 and January 2003. At the time of our visit, medical center managers had begun implementing recommendations that resulted from this BOI to improve security over controlled substances. This suspicious loss and others had not been reported to the OIG as required.

Returned Controlled and Non-Controlled Substances. Medical center policy requires that medications that are dispensed and later returned to the pharmacy by patients or other persons should be inventoried and placed in secured containers in the pharmacy vault. We observed large quantities of medications that had been returned to the outpatient pharmacy and were overflowing from two unsecured containers. Pharmacy Service employees did not know what types of medications were in the containers. At our request, an inventory was conducted that revealed 211 doses of various controlled substances and 9,133 doses of various non-controlled substances.

Prescription Pads. Medical center policy requires that medication prescription pads be accounted for and issued to clinicians only in full, unused pads, and that partial prescription pads are to be destroyed. All prescription pads were accounted for, but not all of the pads on hand were full, unused pads. This occurred because Pharmacy Service

[3] A fact-finding review is the first step taken by management to investigate a problem. If employees involved in the review deem that disciplinary actions may be warranted, a board of investigation may be convened.

employees were not fully aware of the medical center policy; therefore, they had issued individual prescription sheets rather than whole pads to clinicians, and occasionally issued remaining partial pads to other clinicians instead of destroying them. As a result, this practice made it difficult to account for every prescription sheet.

Annual Physical Security Inspections. VHA policy requires that Police Service employees conduct annual physical security inspections of the pharmacy area. Police Service employees conducted these inspections as required and reported their findings to the Medical Center Director. However, the deficiencies identified during the inspections were not corrected. This occurred because Pharmacy Service managers did not receive the inspection reports, and therefore, were not aware of the findings. During our review, Pharmacy Service managers were provided the results of the last inspection and began to initiate corrective actions.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the OIG is notified of suspected thefts, diversions, or suspicious losses of controlled substances; (b) Pharmacy Service employees account for and properly secure returned controlled and non-controlled substances; (c) Pharmacy Service employees comply with medical center policy to issue only full prescription pads; and (d) annual physical security inspection reports are forwarded to Pharmacy Service managers so that corrective actions can be taken.

The VISN Director and the Medical Center Director agreed with the findings and recommendations. Unresolved controlled substances discrepancies will be reported to the OIG. Pharmacy Service employees will inventory, document, and secure all returned medications. New forms for documenting prescription pad inventory were developed and are in use, and a tracking process was developed. Annual physical security inspection reports will be provided to Pharmacy Service managers. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Excess Inventory Needed To Be Reduced and Controls Improved

Condition Needing Improvement. VHA policy establishes a goal that medical facilities carry no more than a 30-day supply of medical, pharmaceutical, prosthetic, and engineering supplies. To assist medical facilities in meeting this goal, VHA policy requires the use of the automated Generic Inventory Package (GIP) for certain types of supplies and recommends similar systems for other types of supplies. Inventory managers can use GIP and similar systems to analyze usage patterns, establish normal stock levels, and determine optimum order quantities. Managers needed to reduce stock levels and improve inventory management controls.

Excessive Stock and Inactive Line Items. Inventory managers implemented GIP in 1995 for medical and surgical supplies controlled by Supply, Processing, and Distribution

(SPD) employees. As of November 30, 2003, SPD maintained an inventory of 711 medical and surgical supply line items valued at $63,987. Of those line items, 591 (83 percent) valued at $42,214 exceeded the 30-day supply standard. These included 120 inactive items with a value of $8,619.

In some cases, excessive inventory levels were unavoidable because of minimum order requirements from mandatory sources and the need to stock low-use supplies for emergency use. In a judgment sample of 20 medical and surgical supply items, 14 (70 percent) had normal stock level settings that exceeded 30 days.

The Prosthetic Inventory Package (PIP) is an automated inventory system used to manage prosthetic supplies. As of December 2, 2003, Prosthetics Service maintained an inventory of 46 line items valued at $15,878. Of these, 34 items (74 percent) valued at $5,417 exceeded the 30-day supply standard. One feature of PIP is the Auto-Generation of Replenishments feature, which saves time and avoids ordering excess stock. Another feature is the Inactive Item Report, which identifies items that are seldom used. Prosthetics Service employees used the Auto-Generation of Replenishments feature for some, but not all, items, and did not use the Inactive Item Report. Because employees maintained a relatively small number of inventory items, they relied on their experience and judgment to replenish stock.

Bar Coding. Both GIP and PIP employ bar coding to improve the accuracy and efficiency of replenishing stock. However, inventory management employees had not implemented bar coding in the medical center at the time of our review, even though the equipment had been purchased. Excessive levels of stock and a high number of inactive line items may be attributable, at least in part, to the fact that the medical center did not use bar coding to identify and track inventory. Managers planned to implement bar coding in SPD and Prosthetics Service by January 2004.

Engineering and Housekeeping Supplies. In a memorandum dated July 1, 2003, VHA mandated the use of GIP no later than October 1, 2003, for six primary inventories including engineering and housekeeping supplies. However, FMS managers had not implemented GIP for engineering and housekeeping supplies, had no plans to do so, and did not use any other inventory system, either automated or manual, to control these supplies. Additionally, FMS employees had not conducted an annual physical inventory in FYs 2003 or 2004. In a judgment sample of 10 supply line items, 9 (90 percent) had excessive stock levels, ranging from 60 days to 3 years.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) reduce inventory stock levels to a 30-day supply and eliminate inactive line items; (b) implement GIP and PIP bar coding; and (c) implement GIP for engineering and housekeeping supplies.

The VISN Director and the Medical Center Director agreed with the findings and recommendations. Inventory levels have been reduced to a 30-day supply, and SPD has begun ordering infrequently used items on an as-needed basis. GIP is in place for all mandated areas. Implementation of PIP is delayed due to a national software problem but is expected to be operational by April 30, 2004. GIP is in place for housekeeping, and engineering supply items will be input by April 15, 2004. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Pharmaceutical Cache Program – Policies and Controls Needed To Be Improved

Condition Needing Improvement. Medical center management needed to incorporate procedures for access, distribution, and use of the pharmaceutical cache into the medical center's Emergency Management Plan. VA's Pharmaceutical Cache Program was established to provide emergency medical support to the general public in the event of a natural disaster, emergency, or terrorist attack. The cache is a stockpile of medications, treatment kits, intravenous solutions, and other medical supplies. There were two areas where management needed to improve the Pharmaceutical Cache Program.

Pharmaceutical Cache Policy. VHA policy requires that facilities have a policy that addresses the activation and utilization of the cache. Although the medical center had both a policy regarding the Pharmaceutical Cache Program and an emergency management plan, neither addressed access, distribution, or use of the cache in the event of an emergency. During our review, the Chief, Pharmacy Service and the medical center's Safety Officer revised the Pharmaceutical Cache Policy and the Emergency Management Plan to address the activation and utilization of the cache.

Accountability of Pharmaceutical Cache Security Bands. Accountability for security bands used to seal cache storage containers needed improvement. Pharmaceutical cache containers were sealed with serially numbered security bands. During unannounced controlled substances inspections, security bands were cut so that inspectors could verify container contents. Although Pharmacy Service employees replaced the bands and recorded the new serial numbers, they did not know how many bands were on hand and did not use the bands in sequential order. Therefore, security bands could be cut, replaced, and a new serial number recorded without their knowledge. During our review, the Chief, Pharmacy Service and the Pharmacy Service QM Coordinator took action to record the serial numbers of all security bands on hand and to require that bands be used and recorded sequentially.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure that the medical center's Emergency Management Plan addresses the access, distribution, and use of the pharmaceutical cache; and (b) improve accountability for pharmaceutical cache security bands.

The VISN Director and the Medical Center Director agreed with the findings and suggestions. Pharmaceutical Cache Policy has been established, and the Emergency Management Plan has been amended to address access and utilization of the pharmaceutical cache. An inventory log for the numbered security bands is now maintained.

Agent Cashier – Unannounced Audit Procedures Needed To Be Improved

Condition Needing Improvement. Physical security of the Agent Cashier area was acceptable, and the amount of the cash advance and turnover rate were adequate. However, certain aspects of unannounced audits needed to be improved.

Audit Timeliness. VHA policy requires that at least two persons skilled in fiscal or audit techniques perform an unannounced audit of cash assets at least every 90 days. Three of the last seven unannounced audits conducted prior to our CAP review (from January 2002 to September 2003) were not performed within 90 days of the preceding audit. The time between audits ranged from 96 to 141 days.

Audit Controls. VHA policy requires that certain elements of unannounced audits be varied to prevent the establishment of a pattern and to maintain an element of surprise. However, the same two individuals conducted all seven of the last audits. In addition, documentation showed that these auditors had received advanced written notice of when the audits would be conducted. The number of days between the notices and the actual audits ranged from 1 to 9 days. In addition, auditors performed three of the seven audits after the assigned dates. The delays ranged from 2 to 9 days.

Audit Procedures. Reports of audits performed on June 30, 2003 and September 9, 2003, showed that funds assigned to an alternate Agent Cashier cash box could not be verified because the only key to the box was missing. The auditors should not have completed those audits without counting the contents of the box. At our request, the auditors broke open the box and found a negligible overage of 50 cents.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) perform unannounced audits of the Agent Cashier funds at least every 90 days; (b) change the employees who conduct unannounced audits and ensure that auditors do not receive advanced notice; and (c) account for the Agent Cashier's assigned funds during unannounced audits and reconcile any discrepancies.

The VISN Director and the Medical Center Director agreed with the findings and suggestions. Unannounced audits of the Agent Cashier were implemented in January 2004, and will be scheduled at least every 90 days. Employees who conduct

unannounced audits are now varied, and no advance notice is provided to the auditors. Assigned funds are accounted for, and discrepancies are reconciled.

Accounts Receivable – Controls Over Accounts Receivable Needed To Be Improved

Condition Needing Improvement. Monthly reviews of aged accounts receivable[4] were conducted. However, Fiscal Service employees needed to pursue collections and off set debts owed by vendors and former employees more aggressively. Fiscal Service employees also needed to timely record and reconcile accounts receivable with individual accounts. To determine if management of accounts receivable complied with VA policies, we reviewed a judgment sample of 10 accounts receivable that were less than 90 days old (value = $5,093) and all 15 of the accounts receivable that were over 90 days old (value = $17,931).

Following Up Accounts Receivable and Off Setting Debts. VA policy requires that accounts receivable be aggressively pursued for collection through demand letters, telephone calls, referrals to consumer reporting or private collection agencies; and as a final step, referrals to the VA Regional Counsel or the Department of Justice for enforced collection. Additionally, vendor debts can be off set against subsequent VA obligations, and debts owed by former employees can be off set against their Government retirement. Among the 15 accounts receivable that were more than 90 days old, there were 9[5] (60 percent, value = $7,603) for which there was no evidence of follow-up. Additionally, there was no evidence that Fiscal Service employees had researched these debts to determine if they could be off set against future VA obligations or employees' Government retirement.

Recording. VA policy requires that accounts receivable be recorded in the month in which it was determined that a debt existed. In our judgment sample of 10 accounts receivable that were less than 90 days old, there were 2 (20 percent, value = $484) that were not recorded timely. The two accounts receivable were for former employees who incurred debts in early October 2003. However, the accounts receivable were not established until the end of November 2003.

Reconciliations. VA policy also requires that accounts receivable general ledger balances be reconciled with individual accounts each month. The accounts receivable reports had not been reconciled beginning with the April 2003 report because the newly hired voucher examiner, who started in her position in May 2003, was not aware of the requirement. Subsequently, accounts receivable reconciliations were not conducted for 8 months.

[4] Aged accounts receivable are more than 30 days old. Accounts receivable over 90 days old are generally considered delinquent.
[5] Four were debts owed by vendors totaling $2,449, and five were debts owed by former employees totaling $5,154.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Medical Center Director requires Fiscal Service employees to: (a) aggressively pursue accounts receivable for collection; (b) research whether debts owed by vendors and former employees can be off set against future obligations and Government retirement, respectively, and, if so, perform the appropriate off sets; (c) timely record accounts receivable; and (d) reconcile accounts receivable with individual accounts monthly.

The VISN Director and the Medical Center Director agreed with the findings and suggestions. Training was provided, accounts receivable were pursued, and debts were researched for future off sets. Accounts receivable were recorded timely, with a turnaround time within 5 business days of the notification of indebtedness to the medical center. As of January 2004, monthly reports on accounts receivable have been reconciled to individual accounts.

Information Technology Security – Controls Needed To Be Enhanced

Condition Needing Improvement. IT security controls were adequate in the areas of security awareness training, risk assessment, virus protection, password controls, and computer room security. In addition, background investigations were appropriate for the sensitivity designations assigned to key positions. However, there were three areas where IT security could be enhanced.

Storage Site for Backup of Critical Data. VA policy requires that backup of critical data processing information be stored "off site." The storage site for the medical center's backup data was located on site, near the main computer processing location. Management should explore with VISN officials establishment of a backup storage site at one of the other facilities within the VISN, or other appropriate off-site storage.

Contingency Plan. The medical center's contingency plan for its Veterans Health Information Systems and Technology Architecture system and Local Area Network needed refinement. The contingency plan did not list locations for alternative meeting places in case of emergencies, and it did not list off-duty telephone numbers for key employees.

Alternate Data Processing Site. The medical center did not have an alternate data processing site. A facility must be able to shift its computer operations to an alternate processing site if an emergency disables the main site. The alternate site should be far enough away from the main processing site so not to be affected by the same event that might affect the main system. According to the Chief, IRM Service, managers were exploring the possibility of using another facility within the VISN, as an alternate processing site, but the technical viability of that option had not yet been tested.

Suggested Improvement Action 4. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) move storage of backup data off site; (b)

include alternative meeting places and off-duty telephone numbers of key employees in contingency plans; and (c) select an alternate data processing site for medical center computer operations.

The VISN Director and the Medical Center Director agreed with the findings and suggestions. A backup storage site was located, a fan-out call system of IRM staff was developed, and VISN 11 is developing an off-site contingency plan and alternate processing site plan for all VISN facilities.

Contract Management – Contract Administration and Contract File Documentation Needed to Be Improved

Condition Needing Improvement. Contract prices and terms were reasonable and properly supported, and contracting employees monitored contracts to ensure that payments to vendors reflected the actual services provided. We reviewed a judgment sample of 10 contracts with a total estimated annual value of $692,000. There were two conditions that needed to be addressed. Contracting employees needed to ensure that a current contract existed before acquiring services, and contract file documentation needed to be improved.

Contract Administration. Medical center employees continued to obtain preventive maintenance services for a laboratory analyzer for a year after the contract had expired. The original contract was for 1 year and was valued at $16,000. A contracting officer mistakenly issued a purchase order for the services against an unrelated contract with the same vendor. A new contracting officer initiated appropriate action by extending the original contract by 6 months.

Contract File Documentation. Federal Acquisition Regulations require that contracting officers ensure that contract files contain all relevant documentation including price negotiation memorandums (PNMs). A PNM documents the facts and considerations controlling the agreement, including any significant differences between the contractor's and contracting officer's positions. Files for 2 of the 10 contracts (20 percent) reviewed (value = $227,000) did not contain PNMs.

Suggested Improvement Action 5. We suggested that the VISN Director ensure that the Medical Center Director requires contracting management to: (a) ensure that a contract exists before issuing purchase orders against it; and (b) include required documents in contract files.

The VISN Director and the Medical Center Director agreed with the findings and suggestions. Acquisition employees are trained to search VA and General Services Administration websites for appropriate Federal Supply Schedules in each acquisition over $2,500. Documentation is included in the delivery order file.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 9, 2004

From: Network Director, VISN 11 (10N11)

Subject: **Aleda E. Lutz VA Medical Center, Saginaw, Michigan - Response to CAP Inspection December 2003 - Project Number 2003-03038-HI-0375**

To: Director, Management Review Service (10B5)

1. We are submitting written comments in response to the Combined Assessment Program Review completed in December 1-5, 2003, for the Aleda E. Lutz VA Medical Center in Saginaw, Michigan.

2. In review of the Draft Report, the facility has addressed all identified deficiencies and is continuing to improve and resolve non-compliance in areas cited.

3. If you have any questions regarding the content of this report, please contact Gabriel Pérez, Medical Center Director at the Saginaw VAMC, at (989) 497-2500, ext. 3000.

(original signed by:)

Linda W. Belton

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) review driving records of MVOs and volunteer drivers for violations, convictions, and other abuses; (b) ensure physical examinations and verifications of personal insurance are accomplished for volunteer drivers; (c) require that all individuals who transport patients receive annual safe driving training, and training is documented; (d) ensure that the contract transport vendor annually submits the required documentation regarding drivers' competencies; (e) ensure that patients scheduled for transport are assessed for escort needs, and procedures are developed to report to clinical employees and document in medical records significant patient events that occur during transport; and (f) explore options to minimize travel time for patients required to travel on stretchers.

Concur **Target Completion Date:** April 30, 2004

(a) Employee motor vehicle operators have been assessed for current driver's license and a review of their driving records has been completed. This information is on file with the Employee Health Coordinator. All employees are currently cleared to continue performing under their current driver qualifications. Driving records of volunteer drivers were reviewed for violations, convictions and other abuses. An annual review of the driver's license and driving record is being completed at the time of the driver's birthday. Completed.

(b) A physical exam for all our volunteer drivers has been completed. Personal insurance has also been verified. An annual review of personal insurance is now completed at the time of the driver's birthday. An annual physical is being completed on the anniversary of the volunteers enter-on-duty date. Completed.

(c) Employee motor vehicle operators are currently completing job-level training on safe/defensive driving. This level of training will be incorporated into future and ongoing job-level training. A Safe Drivers Course is now a required annual training for the volunteer drivers. This will be completed on initial orientation and annually thereafter. Voluntary Service is scheduling training with Facilities Management Service for volunteer drivers which will be accomplished not later than April 30, 2004.

(d) The contract ambulance source provides an annual report that validates drivers licensure, Basic Life Support/Advance Life Support training, and competencies of their staff. This report is on file with the ambulance contract representative at the Saginaw VAMC.

(e) Patients requesting outpatient transportation are initially screened for ambulation, use of oxygen, or other needed assistance with ADLs before they can be accepted. If the patient needs assistance in any manner, they receive an attendant. Attendants are responsible for documenting any significant events that occur during transport into the CPRS upon return. Further assessment by a clinical nurse or provider will be completed if initial screening indicates.

(f) Patients traveling by stretcher are given priority for appointments at tertiary care sites. Should an outpatient request a courtesy ride, his/her appointment must be within a reasonable time of the stretcher patient's appointment so that the patient on the stretcher will not be made to wait.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) patient safety and maintenance deficiencies are corrected; (b) patient privacy is protected in the APU/OR; (c) biohazardous storage rooms are secured; (d) employees are trained and able to describe emergency evacuation procedures; (e) VCS employees practice proper infection control procedures; and (f) routine cleaning and maintenance of the VCS is accomplished according to VCS standards.

Concur **Target Completion Date:** May 31, 2004

(a) Open walls in APU/OR area were abated 12/03. Walls have been properly patched. Regarding construction in the Ambulatory Procedure Unit/Operating Room (APU/OR), a mechanism is in place to oversee construction projects and is described in MCM 00-21, Construction Risk Reduction and Infection Control (IC) dated May 2003. High-risk construction requires IC and Safety sign-off prior to beginning the project. Evidence of implementation of this plan is documented in Safety and IC Committee minutes. During projects, daily observations are made of the construction site.

The APU/OR finding was a unique situation limited to an area of wall/ceiling in a room, behind a closed door in the OR where completion of this room had been on hold. A poly dust barrier had been in place, consistent with hospital policy. Managers were aware of this as a known construction area as the Hazard Surveillance Team had periodically monitored the area during rounds in the accompaniment of the OR Manager. However, during the IG inspection, the poly dust barrier was found to have partially fallen down. Because the construction area/poly dust barrier was in a back room of the OR, behind a closed door, managers were not aware the poly had fallen. This has already been corrected by replacing the barrier and subsequently completing the construction. Walls and tiles were installed. Future practice will be to use wallboard rather than poly for barriers requiring longer duration. It should be noted that no increase in surgical wound infections or respiratory symptoms occurred during that time period. No further action is necessary.

Exit Door Assessment - A risk assessment was performed at the direction of the Environment of Care Committee regarding the exit door to the ICF by the loading dock which is alarmed by the wander alert system. At this time, it was determined that no action is needed and will be reasseesed in 6 months. Repairs for railings throughout the facility have been completed.

Response to Call Lights in the Interim Care Facility - there is currently a HFMEA in process in which one of the recommended actions being pursued is to install an amplification system that will direct the sound of the call light bells down each corridor for enhanced audibility. This should be accomplished not later than May 31, 2004.

(b) Space issues in the APU/OR are noted and mechanisms have been in place to control them since additional space has not been immediately available. At this time, domino moves are being made to open up space for expansion and re-design of the area slated for completion this year. In the interim, we will control risk factors on a case-by-case basis. To facilitate privacy in the APU/OR, staff performs initial assessment of patients prior to surgery at the bedside or in a private exam room within the surgical suite. However, when patients are pre and post op in the APU, staff are reminded to keep voices to a minimum and be cautious when communicating confidential information in that work area. Again, to communicate sensitive information, the patient can be taken to a private exam room within the OR if indicated. Computer screens can be minimized instantly and the screens automatically switch to screen saver after 60 seconds.

(c) The room in question is a soiled utility room and holds a mop and bucket. The use of this room was evaluated. It is not a biohazardous storage room. The biohazard label was found to be un-necessary and has been removed.

(d) Staff response to evacuation during fire emergency is spot checked during a safety awareness survey semi-annually. Refresher training was also conducted in nursing and housekeeping. Evacuation is also reviewed at the annual fire safety training and is included in mandatory Synquest training annually. Nursing staff in acute care and interim care facility are currently receiving additional job-level training on evacuation procedures as outlined in Medical Center Memorandum 00-22, Medical Center Emergency Management Plan which is to be accomplished not later than 4/30/04.

(e) Regarding the multipurpose sink in the Veterans Canteen Service (VCS) kitchen, employees were reminded of the disinfecting procedure at an inservice. Additionally, Canteen staff are taking advantage of attending ongoing inservices presented by our Nutrition and Food Service. For the ice machine, a handle was installed and a container supplied for storage of the ice scoop. It continues to be sanitized daily. There are now check sheets mounted throughout the Canteen with sanitation instructions and for documenting the various cleaning activities. The uncovered trash container by the elevator has been removed and will no longer be stored in that area.

(f) Cleaning in the Veterans Canteen Service (VCS) is a joint responsibility of Facility Management (FMS) and Canteen Services employees. The area is inspected on a quarterly basis by the Hazard Surveillance Team in the accompaniment of the Chief, Canteen Service. Despite being new to the positions, the Chiefs of Canteen and FMS have been making significant improvements/changes. In support of their efforts, in response to the IG findings, and to ensure ongoing cleaning and maintenance is sustained, a team approach was taken and areas corrected as follows:

(1) A formal policy, Medical Center Memorandum 133-02, was established with written responsibilities and frequency clearly delineated and mutually agreed upon.

(2) Problem solving discussions occurred regarding cleaning techniques, cleaning supplies and moving of equipment, for example a new grease cutting sanitizer, Green Solutions Industrial Cleaner, is being used. New floor mats were purchased in adequate supply to allow them to be rotated and removed from the kitchen for thorough cleaning. The external surfaces of hoods and filters are cleaned weekly by Canteen staff. An outside vendor conducts thorough cleaning of internal surfaces semi-annually in October and April. Plans are underway to increase the frequency of this service to quarterly.

(3) The missing and broken wall tile was repaired along with the window frame.

(4) The height of the open ceiling in the storeroom, which precluded routine cleaning was corrected with a new dropped ceiling (and lighting). This has resolved this issue as well as dramatically improved appearance and visibility in the storeroom as well.

(5) New trash cans were purchased.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish and implement accountability procedures for medical center keys and distribute keys only to employees who have certifications of need by service chiefs or a higher authority; and (b) re-key vulnerable areas, such as medication rooms, and implement plans to re-key remaining locks or convert to an electronic key system.

Concur **Target Completion Date:** August 31, 2004

(a) An environmental security risk assessment was completed. The entire key control program is being realigned under Police Service. They will establish a process for controlled request and assignment of keys. FMS will only make keys under Police's recommendations. The policy and enhanced process are nearing completion at this time.

(b) The entire Medical Center is currently being re-cored/re-keyed through a phase-in approach. It is expected that all exterior and interior doors will be completed not later than August 31, 2004. Currently, improvements have been made to secure high risk areas such as medication rooms.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the OIG is notified of suspected thefts, diversions, or suspicious losses of controlled substances; (b) Pharmacy Service employees account for and properly secure returned controlled and non-controlled substances; (c) Pharmacy Service employees comply with medical center policy to issue only full prescription pads; and (d) annual physical security inspection reports are forwarded to Pharmacy Service managers so that corrective actions can be taken.

Concur **Target Completion Date:** May 31, 2004

(a) All unresolved discrepancies are reported to Police Service. The VAMC Quad is informed of the discrepancy which is then reported to OIG. Completed.

(b) All medications returned will be inventoried and documentated on a return log sheet. They are then secured in a tamper-evident envelope. Controlled substances will be stored in the pharmacy narcotic vault. All medications will be destroyed via Guaranteed Returns. Completed.

(c) New forms for the documentation of prescription pad inventory have been developed and are in use. A tracking log, approved by the inspector, has been implemented for the issuing and tracking of individual forms. Completed.

(d) Annual physical security inspection reports will be provided to pharmacy service managers per Police Service. The next inspection will be completed not later than May 31, 2004.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) reduce inventory stock levels to a 30-day supply and eliminate inactive line items; (b) implement GIP and PIP bar coding; and (c) implement GIP for engineering and housekeeping supplies.

Concur **Target Completion Date:** April 30, 2004

(a) Steps have been taken to reduce inventory levels to a 30-day supply by maintaining a 30-day reorder level and making more frequent purchases. Supply Processing and Distribution (SPD) has discontinued stocking some of their more infrequently used items, ordering them on an as-needed basis. Completed

(b) The Generic Inventory Package (GIP) is in place for all mandated areas and functioning well. The Prosthetic Inventory Package (PIP) and equipment is on site but there is a national software problem and we are awaiting approval to implement use. Tentative completion date is April 30,2004.

(c) GIP in place for housekeeping. Engineering supply items are in the process of being entered and should be finished by April 15, 2004.

OIG Suggestion(s)

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure that the medical center's Emergency Management Plan addresses the access, distribution, and use of the pharmaceutical cache; and (b) improve accountability for pharmaceutical cache security bands.

Concur **Target Completion Date:** Completed

(a) A policy has been developed and implemented regarding the Drug Cache. The Emergency Management Plan has been amended to incorporate accessing and utilizing the Drug Cache through Medical Center Memorandum 119-09, Pharmacy Drug Cache. The Safety Manager will establish drills to exercise the cache.

(b) An inventory log for the numbered security bands is now sequentially maintained.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) perform unannounced audits of the Agent Cashier funds at least every 90 days; (b) change the employees who conduct unannounced audits and ensure that auditors do not receive advanced notice; and (c) account for the Agent Cashier's assigned funds during unannounced audits and reconcile any discrepancies.

Concur **Target Completion Date:** Completed

(a) Unannounced audits of the Agent Cashier were implemented in January 2004. These audits are scheduled at least every 90 days.

(b) Audit staff are varied, and no advance notice is given to Agent Cashier staff.

(c) All Agent Cashiers assigned funds are accounted for, and a process is in place to reconcile discrepancies. All improvement actions recommended by the IG have been implemented.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Medical Center Director requires Fiscal Service employees to: (a) aggressively pursue accounts receivable for collection; (b) research whether debts owed by vendors and former employees can be off set against future obligations and Government retirement, respectively, and, if so, perform the appropriate off sets; (c) timely record accounts receivable; and (d) reconcile accounts receivable with individual accounts monthly.

Concur **Target Completion Date:** Completed

(a) Additional training has been given to the employee responsible for Non-MCCR Accounts Receivable. Open Accounts Receivable balances have decreased from $45,711 in November 2003 to $21,482 in March 04, due to increased collection activity. Prior Fiscal Year balances have been reduced from $45,106 in November 03 to $18,093 in March 04.

(b) Debts are researched for future offset against future obligations and Government retirement and aggressively pursued. A process is in place currently that allows the US Department of Treasury to offset an ex-employee's tax return or government benefit, or offset vendor debt against future obligations, as examples.

(c) Account Receivables are recorded in a timely manner, with a turnaround time within 5 business days of the notification of indebtedness to the VA.

(d) As of January 04, the monthly report on Accounts Receivables (853) is reconciled to individual accounts.

Suggested Improvement Action 4. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) move storage of backup data off site; (b) include alternative meeting places and off-duty telephone numbers of key employees in contingency plans; and (c) select an alternate data processing site for medical center computer operations.

Concur **Target Completion Date:** June 30, 2004

(a) A back-up storage site is being utilized by an additional set of back-up tapes being taken to a staff member's home. The facility is currently on a waiting list for a post office box at Saginaw Post Office.

(b) Chief, IRM initiates fan-out call system of IRM staff who will report to Ann Arbor VAMC at the direction of the Chief, IRM. VISN 11 is collaboratively developing an off-site contingency plan for all VISN facilities.

(c) A VISN workgroup has been formed that is addressing alternate processing site plans for all facilities in VISN 11.

Suggested Improvement Action 5. We suggested that the VISN Director ensure that the Medical Center Director requires contracting management to: (a) ensure that a contract exists before issuing purchase orders against it; and (b) include required documents in contract files.

Concur **Target Completion Date:** Completed

Acquisition personnel are trained to search the VA and GSA websites for appropriate federal supply schedules (FSS) in each acquisition over $2,500.00. If an FFS is identified as being an appropriate vehicle for issuing delivery orders against it, a copy of the FSS is either downloaded, if available on the website, or requested from the FSS holder if not available on the website. Documentation is included in the delivery order file.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5(a)	Reduction of excess supply inventory would permit better use of medical center funds.	$47,631
N/A	Following up on delinquent accounts receivable or offsetting vendor and employee accounts receivable against future obligations and retirement funds would increase collections.	$7,603
	Total	$55,234

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson (708) 202-2672
Acknowledgments	Paula Chapman Mark Collins Patricia Conliss Kenneth Dennis William Gerow Kevin Gibbons Theresa Golson Terrye Hall Katherine Owens John Pawlik Leslie Rogers William Wells

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 11
Director, Aleda E. Lutz VA Medical Center

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
General Accounting Office
Office of Management and Budget
Senator Carl Levin
Senator Debbie Stabenow
Representative David Lee Camp
Representative Dale E. Kildee
Representative Bart Stupak

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.