Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System

Report No. 04-01718-222 **September 29, 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.

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Executive Summary

Introduction

During the week of April 19-23, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the North Florida/South Georgia Veterans Health System (System). The purpose of the review was to evaluate selected System operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided seven fraud and integrity awareness briefings to 258 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 8.

Results of Review

This CAP review focused on 12 areas. The System complied with selected standards in the following areas:

- Environment of Care
- Government Purchase Card Program
- Moderate Sedation
- Quality Management

We identified eight areas that needed additional attention. To improve operations, the following recommendations were made:

- Implement prior CAP recommendations to delete the laundry project from the Capital Asset Plan and centralize food production operations to the System's Lake City facility.
- Obtain eyeglass services through a competitive solicitation.
- Improve controls over preparation and security of surgical case carts.
- Improve controls over supply inventory management.
- Improve the monthly inspection program, security, and inventory controls over controlled substances.
- Implement a telephone access security system.
- Improve automated information systems (AIS) security.
- Improve controls over part-time (PT) physicians' time and attendance procedures.

This report was prepared under the direction of Mr. James R. Hudson, Director, and Mr. Floyd C. Dembo, CAP Review Coordinator, Atlanta Audit Operations Division.

Acting VISN 8 Director and System Director Comments

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 15 – 23 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(original signed by Jon A. Wooditch,
Deputy Inspector General for:)
RICHARD J. GRIFFIN
Inspector General

Introduction

System Profile

Organization. The North Florida/South Georgia Veterans Health System is a tertiary care system that provides a broad range of inpatient and outpatient health care services at two medical centers located in Gainesville and Lake City, Florida. Outpatient care is also provided at eight community-based outpatient clinics located in Daytona Beach, Inverness, Jacksonville, Leesburg, Ocala, St. Augustine, and Tallahassee, Florida; and Valdosta, Georgia. The System is part of VISN 8 and serves a veteran population of about 477,000 in a primary service area that includes 33 counties in Florida and 19 counties in Georgia.

Programs. The System provides medical, surgical, mental health, geriatric, and rehabilitation services. The System has 265 hospital beds and 260 nursing home beds. In addition, the System has sharing agreements with the Naval Air Station Jacksonville in Jacksonville, Florida.

Affiliations and Research. The System is affiliated with the University of Florida Colleges of Medicine, Dentistry, Nursing, Physical Therapy, Health Services Administration, and Pharmacy; and supports 112 medical resident positions in 26 training programs. Other affiliations include Florida State University, Valdosta State University, Santa Fe Community College, and Lake City Community College. In Fiscal Year (FY) 2003, the System's research program had 328 projects and a budget of $13 million. Important areas of research include neuro-regeneration outcomes and vascular biology.

Resources. In FY 2003, the System's medical care expenditures totaled $411 million. The FY 2004 medical care budget is $459 million. FY 2003 staffing totaled 3,155 full-time equivalent (FTE) employees, including 184 physician and 629 nursing FTE.

Workload. In FY 2003, the System treated 105,704 unique patients. The System provided 61,215 inpatient days of care in the medical centers and 76,072 inpatient days of care in the nursing homes. The System's inpatient care workload totaled 9,608 discharges, and the nursing home workload totaled 622 discharges. The System's average daily census was 167 for the medical centers and 209 for the nursing homes. The total outpatient workload was 995,035 visits.

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 patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices 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. We also followed up on the recommendations and suggestions included in our previous CAP report of the facility *(Combined Assessment Program Review North Florida and South Georgia Veterans Health System, Report No. 9IG-CAP-502, dated April 22, 1999).* The review covered facility operations for FY 2003 and FY 2004 through April 23, 2004,[1] 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 selected aspects of the following activities:

Contract Administration	Moderate Sedation
Controlled Substances Accountability	Quality Management
Environment of Care	Surgical Case Cart Management
Government Purchase Card Program	Supply Inventory Management
Implementation of Prior CAP Recommendations and Suggestions	Telephone Access Security System
Information Technology Security	Timekeeping for Part-time Physicians

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The survey results were provided to medical center management.

During the review, we also presented seven fraud and integrity awareness briefings to 258 System employees. These briefings 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.

[1] We extended our review of missing and contaminated surgical instruments through July 12, 2004.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-14). For these activities we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Opportunities for Improvement

Prior CAP Follow-Up – Prior CAP Report Recommendations Needed To Be Implemented

Condition Needing Improvement. Not all of the recommendations in the previous OIG CAP report issued in April 1999 were implemented. The report contained 10 recommendations and 9 suggestions. The System Director agreed to implement 8 of the recommendations and the 9 suggestions, and deferred action on implementing the personal identification number (PIN) telephone access security system and means test line authority recommendations pending further study.

Our follow-up review of the areas showed that System management did not satisfactorily implement recommendations in the following areas:

- Supply inventory management controls were not improved.
- Controlled substances monthly inspections were not performed in all areas.
- The PIN telephone access security system was not implemented.
- The project to construct a new laundry was not removed from the Capital Asset Plan.
- Food production operations were not centralized to the System's Lake City facility.

We also determined that our suggestion to improve subsidiary time and attendance procedures for PT physicians was not satisfactorily implemented.

The above conditions identified in our prior report continued to exist at the time of our review. Our repeat findings concerning inventory management controls, controlled substances inspections, telephone access security system, and PT physician time and attendance procedures are presented in the following section of this report.

Subsequent to our current CAP review, System management advised us that they would delete the laundry project from the Capital Asset Plan and centralize food production operations to Lake City.

Recommended Improvement Action(s) 1. The Acting VISN 8 Director should ensure that the System Director takes action to:

a. Delete the laundry project from the Capital Asset Plan.

b. Centralize food production operations to Lake City.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Contract Administration – Competitive Solicitation Is Needed For Eyeglass Services

Condition Needing Improvement. The System could have saved about $560,000 by competitively obtaining eyeglass services. During the period August 1, 2001, through July 31, 2004, the System paid about $3.73 million to a vendor for eyeglass services under a non-competitively awarded Veterans Canteen Service (VCS) contract.

The vendor under contract with the VCS was the same vendor that provided VA Medical Center (VAMC) Miami with eyeglass services under a competitively awarded VISN contract. The System did not participate in the VISN eyeglass services solicitation, electing to use the VCS contract instead. The VCS contract stipulated that the vendor would pay the VCS 5 percent of the gross receipts from System-ordered eyeglasses the first year and 4 percent for the remaining years. The VCS contract's option year expired July 31, 2004.

A comparison of the VAMC Miami and the VCS contracts showed that VCS contract prices were higher. A sample of 30 eyeglass purchases under the VCS contract totaling $2,329 would have cost $1,971 had they been purchased from the same vendor under terms similar to the VAMC Miami contract, resulting in a savings of $358 ($2,329-$1,971), or about 15 percent ($358/$2329). We estimate that the System could have saved about $560,000 (15 percent of $3.73 million), from August 1, 2001, through July 31, 2004, by participating in the VAMC Miami contract solicitation.

Recommended Improvement Action(s) 2. The Acting VISN 8 Director should require that the System Director obtain eyeglass services through competitive solicitation.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendation, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Surgical Case Cart Management – Controls Over Preparation and Security of Carts Needed Improvement.

Condition Needing Improvement. During the period October 1, 2003, through July 12, 2004, the System identified 104 incidents of missing, broken, or contaminated

instruments on surgical case carts. System staff said that incidents related to surgical instruments did not adversely affect patient care. We reviewed seven patient incident reports that were related to episodes of missing or contaminated surgical instruments and found that there were no adverse patient outcomes.

While we found no evidence that surgeries were canceled, the Operating Room (OR)/ Supply Processing and Distribution (SPD) Work Group minutes dated March 31, 2004, stated that "missing instruments are causing delays in OR cases and subjecting patient (sic) to additional anesthesia time." According to the OR Nurse Manager, surgical supplies and instruments were regularly missing from surgical case carts.

The Associate Chief, Nursing Service (ACNS) for Surgery began monitoring problems with surgical instrumentation and supplies on case carts when she assumed her position in July 2003. System management also established a work group that included OR and SPD staff to deal with the issues of contaminated and missing items on case carts in October 2003. According to System staff, they held seven meetings between October 2003 and April 2004. However, they could only provide minutes for four meetings (October 2003, March 2004, and two for April 2004). In March 2004 the System began to more aggressively monitor case carts, including the collection of additional information such as identifying the specific problems with the instruments on the case carts in order to determine necessary corrective actions. The service chiefs reported weekly to the System Director items of interest and corrective actions that were needed to resolve instrumentation issues.

The ACNS for Surgery identified the following incidents during the period October 1, 2003, through July 12, 2004:

- 34 missing instruments.
- 19 contaminated instruments.
- 15 wrong instruments for the procedure.
- 7 broken instruments.
- 29 other miscellaneous items (Examples include cloth pack on cart with outer wrapper torn in two places and instrument container label wrong.)

Our review of OR/SPD Work Group minutes, weekly OR/SPD *Items of Interest* reports to the Director, and other available data for the period October 1, 2003, through July 12, 2004, indicates that items were missing from case carts because:

- SPD frequently sent case carts to the ORs with missing items, with the intention of delivering the missing items to the ORs before the scheduled surgeries.
- Case carts were not secured and items were removed from one cart to perform another procedure because the cart for that particular procedure was missing the item.

We found that System management has taken a number of actions to resolve the instrumentation issues, including:

- Authorizing SPD 10 additional FTE.
- Purchasing case carts that can be secured.
- Purchasing additional surgical instruments ($187,000 in the 3rd quarter of FY 2003).

Actions being taken by System management appear to be reducing the number of identified incidents. We compared the incidents identified by the System for March and April 2004 with those for May and June 2004 and found that the number of incidents decreased for missing instruments (20 to 8), wrong instruments (7 to 5), broken instruments (4 to 2), and other incidents (18 to 8). However, the number of incidents of contaminated instruments increased from 5 to 8.

While the weekly OR/SPD *Items of Interest* reports and the minutes of the work group meetings addressed corrective actions taken, such as purchasing additional instruments, they did not address the systemic problems that caused the incidents to occur. We also found that contaminated instruments were not addressed in the March and April 2004 minutes when the number of these incidents increased. A review of OR/SPD inventory and surgical cart procedures needs to be conducted to ensure that all systemic problems have been identified and corrective actions taken.

Recommended Improvement Action(s) 3. The Acting VISN Director should require that the System Director conduct a review of OR/SPD inventory and surgical cart procedures to ensure that all systemic problems have been identified and corrective actions taken.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendation, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Supply Management – Inventory Controls Needed Improvement

Condition Needing Improvement. In our prior CAP report, we recommended that the System reduce stock levels to no more than 30 days supply, conduct a complete inventory of all inventory areas, adjust the stock levels in the Generic Inventory Package (GIP) to show accurate and complete data, and enter all inventory points in GIP. We found that 3 of these 4 conditions still existed at the time of our current review. Stock levels were not reduced, GIP did not contain accurate and complete data, and all inventory points were not in GIP. We also found that barcode scanners were not used to manage inventories.

Veterans Health Administration (VHA) policy requires medical facilities to use GIP to establish inventory levels, set reorder quantities, and track usage of supplies.

The following conditions required management attention:

Excess Stock-on-Hand. We sampled 40 SPD stock items, 20 at Gainesville and 20 at Lake City, and conducted a physical inventory of the items. Our inventory of SPD stock items showed that 27 of 40 (67.5 percent) stock items sampled exceeded 30-day stock levels. The total value of the 27 stock items that exceeded the 30-day stock levels was about $34,000, and the value of the excess stock was about $17,600. Using the sample results, we estimated that 1,837 of the 2,721 items on-hand had stock valued at about $92,400 in excess of the 30-day stock levels.

Inventory Balances. GIP inventory records did not agree with actual quantities on-hand for some SPD stock items. We found that the inventory totals in GIP were either understated or overstated for 28 of 40 (70 percent) SPD stock items. Twenty stock items were understated (more items on-hand than recorded in GIP) and 8 stock items were overstated (less items on-hand than recorded in GIP).

Use of Barcode Scanners. Even though computerized barcode labels were available in 5 of the 9 inventory points, only SPD used the scanners to conduct annual inventories, and none of the inventory points used the scanners to record receipts and issues. The barcode scanner is used to scan the label to identify the stock item, and then the quantity is entered into the scanner. After inventorying, receiving, or issuing stock items, the information is uploaded into GIP, and the inventory quantities are adjusted accordingly. The information is also used to generate reorder quantities, when appropriate. Using the barcode scanners increases the accuracy of information entered into GIP after inventorying, receiving, and issuing stock items, and results in more reliable stock inventory balances.

Recommended Improvement Action(s) 4. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. Stock levels in GIP are updated and reduced to 30 days' supply.

b. Barcoding, scanning, and labeling procedures are implemented to manage all inventory points.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Controlled Substances – Monthly Inspection Program, Security, and Inventory Controls Needed Improvement

Condition Needing Improvement. The Chief, Pharmacy Service, was inappropriately appointed as the Controlled Substances Coordinator (CSC); controlled substances inspections were not performed monthly, nor were they random and unannounced; and controlled substances inspectors did not use volumetric cylinders to measure liquid substances during inspections. The following conditions required management attention:

- In June 2000, the System Director designated the Chief, Pharmacy Service, as the CSC to oversee the controlled substances program. According to VHA policy, the CSC must not have any immediate connection with the controlled substances program including procurement, dispensing, or record keeping of controlled substances. During our review, the System Director appointed a new CSC; therefore, we are not making a recommendation concerning this issue.
- During the period of February 1, 2003, to January 31, 2004, only 386 of the 432 (89 percent) required monthly inspections at Gainesville were performed. VHA policy requires that all locations with controlled substances be inspected each month.
- The System's policy required that controlled substances inspections were to be completed by the 15th of the month. Inspections of nursing units had to be performed between 11 a.m. and 2 p.m. This policy precluded the element of surprise and randomness of inspections. VHA policy requires that inspecting officials conduct random, unannounced inspections each month.
- During our unannounced inspection, controlled substances inspectors did not use a volumetric cylinder to measure liquids. VHA policy requires that the inspectors measure all unsealed liquids with a volumetric cylinder.

Recommended Improvement Action(s) 5. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. Monthly controlled substances inspections of all locations with controlled substances are performed randomly and unannounced at Gainesville.

b. Controlled substances inspectors use volumetric cylinders to measure liquids during inspections.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Pharmaceutical Manufacturer Representatives – Monitoring of Gifts to System Staff Needed Improvement

Condition Needing Improvement. Pharmaceutical manufacturer representatives provided meals to System staff that exceeded the definition of food items of nominal value as described in VHA policy. While conducting a controlled substances inspection at Lake City, we observed a pharmaceutical representative bringing a multi-course Chinese meal for System staff attending an unscheduled training session in Psychiatry Service. VHA policy states, "Sales representatives may provide food items of nominal value (e.g., soft drinks, coffee, donuts, and other light refreshments are permissible; meals are not) to VA employees when incidental to a scheduled meeting or legitimate educational interchange and are not otherwise prohibited by government ethics rules and/or education accreditation requirements."

Our review of the Pharmaceutical Manufacturer Representatives Sign-in Sheet disclosed that representatives from the same company made 26 visits to Lake City between October 1, 2003, and April 16, 2004. Company representatives made 10 visits each to Psychiatry Service and the Nursing Home Care Unit. Further review showed that during that same period, representatives of 22 companies made 115 visits to Lake City, while 8 of these companies made 5 or more visits. While the sign-in sheet did not always indicate if food items were being provided, we were told this was a common practice and that representatives frequently made unscheduled visits. System management needs to more closely monitor pharmaceutical manufacturer representatives to ensure that an appropriate business relationship is maintained and to avoid the appearance of violating Government ethics rules.

Recommended Improvement Action(s) 6. The Acting VISN 8 Director should require that the System Director takes action to ensure that:

a. An appropriate business relationship is maintained with pharmaceutical manufacturer representatives.

b. Government ethics rules are enforced.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Telephone Access Security System – Monitoring of Long Distance Telephone Calls Needed Improvement

Condition Needing Improvement. System management did not implement the PIN telephone access security system to ensure charges for long distance telephone calls are

appropriate and necessary, as recommended in the CAP report issued in April 1999; nor did management implement an alternate system to monitor long distance telephone calls. The previous System Director stated that he wanted to defer immediate action on the recommendation in the April 1999 CAP report pending further study and evaluation. However, management did not perform a survey to evaluate the need to implement the PIN system, because they did not believe that long distance telephone calls were excessive.

Information Resource Management (IRM) staff had not performed evaluations of long distance telephone calls to determine if they were necessary or appropriate, nor did System management provide any information to suggest that an evaluation of long distance telephone calls was not needed. IRM staff was unable to provide the actual long distance telephone call costs for FYs 2003 and 2004 through February 28, 2004, because they had not been monitoring such calls.

PIN systems are in general use at most VISN 8 medical centers. We found that 4 out of 6 VISN 8 facilities use a PIN system and reported significant decreases in long distance telephone calls. We also found that the System's Private Branch Exchange has the capability to run the PIN telephone access security software.

Recommended Improvement Action(s) 7. The Acting VISN 8 Director should ensure that the System Director takes action to implement a PIN telephone access security system or implements a process to monitor long distance telephone calls to ensure they are appropriate and necessary.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Information Technology – Security Needed Improvement

Condition Needing Improvement. AIS security conditions required management attention. The System's Veterans Health Information System and Technology Architecture (VISTA) contingency plan was not complete; VISTA and Local Area Network (LAN) systems risk assessments had not been performed; quarterly reviews of AIS access had not been performed; VISTA back-up tapes at Lake City were not stored away from the computer room; and System staff did not complete required computer security awareness training.

VISTA Contingency Plan. The System's VISTA contingency plan did not include:

- Mission-critical functions and the resources needed to support the functions.

- A disaster recovery team, with roles and responsibilities of key System staff defined.
- Hardware and software configurations of major AIS.
- VISTA back-up tapes and the labeling scheme used to identify back-up tapes.

Risk Assessments. The System had not performed risk assessments for the VISTA and LAN systems. VHA policy requires risk assessments be conducted of major AIS, including the VISTA and LAN systems. During the course of our review, the System completed the risk assessments for the VISTA and LAN systems.

Monitoring AIS Access. The Information Security Officer (ISO) did not perform quarterly reviews of the continued need for AIS access. As of April 8, 2004, the System had 1,419 VISTA access accounts. We found:

- 177 accounts had never been accessed, including 4 that were established in 1987.
- 107 VISTA accounts had not been accessed in over 90 days, ranging from 117 days to 6,460 days.

These accounts should be reviewed and action taken to terminate them where appropriate. Quarterly reviews should be performed to identify and terminate accounts that are not needed.

Monitoring Sensitive Records Access. System reviews of employee access to sensitive employee medical records and corrective actions taken were not documented. According to VHA policy, the Sensitive Record Access Log should be reviewed regularly. The ISO said that he did not monitor such access. Although the alternate ISO told us he monitored the access monthly, he could not provide documentation of the reviews or corrective actions taken.

VISTA Back-up Tapes. VISTA back-up data tapes were stored on top of the servers in the Lake City computer room. VHA policy requires back-up tapes to be stored away from the computer room.

Computer Security Awareness Training. During the period April 1, 2003, through March 31, 2004, only 68 percent of the System staff received computer security training. VHA policy requires that AIS security awareness training be provided to all staff. The ISO should improve monitoring of training to ensure that all System staff participates in annual AIS security awareness training.

Recommended Improvement Action(s) 8. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. The VISTA contingency plan is comprehensive and contains key elements to ensure effective contingency planning.

b. Risk assessments are completed for the VISTA and LAN systems.

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

d. Monitoring of employee access to sensitive records is performed regularly and the results are documented.

e. VISTA back-up tapes are stored away from the computer room.

f. Security awareness training is provided to all System staff.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Part-time Physicians – Subsidiary Time and Attendance Reports Needed Improvement

Condition Needing Improvement. The prior CAP suggestion to properly complete PT physician subsidiary time and attendance reports was not implemented and continues to require management attention. Our review of *Subsidiary Time and Attendance Reports* (VA Form 4-5631a) for 23 PT physicians in Ambulatory Care, Medical Service, and Surgical Service showed that the VA Form 4-5631a for each physician was not properly completed. We found a variety of missing elements, including the physician's core hours, physician and supervisor signatures, and timekeeper initials. This condition went uncorrected because Employee Accounts Section staff did not perform semiannual desk audits of all timekeepers during the past 2 years. The Chief, Finance Section, stated that the semiannual timekeeper desk audits were not consistently performed because of staff vacancies.

Recommended Improvement Action(s) 9. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. PT physicians provide timekeepers completed *Subsidiary Time and Attendance Reports*.

b. Employee Accounts Section staff perform semiannual desk audits of all timekeepers.

The Acting VISN 8 Director and the System Director agreed with the findings and recommendations, and the Acting VISN 8 Director agreed with the System Director's

corrective action plan. The System Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Appendix A

Acting VISN 8 Director's Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2004

From: Acting VISN 8 Director's Comments

Subject: **North Florida/South Georgia Veterans Health System**

To: Director, Atlanta Audit Operations Division

1. Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the NF/SG VHS.

2. I agree with the findings of the report and with the response and action plan submitted by the System Director.

(original signed by Nancy Reissener,
Deputy VISN Director for:)

DENNIS M. LEWIS, FACHE

Appendix B

System Director's Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2004

From: System Director's Comments

Subject: **North Florida/South Georgia Veterans Health System**

To: Acting Network Director VISN 8 (10N8)

1. I have reviewed the findings within the report of the Combined Assessment Program Review of the North Florida/South Georgia Veterans Health Service and I am in agreement.

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

(original signed by:)

F. L. MALPHURS

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The Acting VISN 8 Director should ensure that the System Director takes action to:

a. Delete the laundry project from the Capital Asset Plan.

b. Centralize food production operations to Lake City.

Concur **Target Completion Date:** 12/31/2004

a. A memo dated August 9, 2004 was sent from the NF/SGVHS Director, to Network Director (10N8) advising that minor project No. 573A4-310 (LC Division) Construct Laundry will be deleted for the next cycle of the updated "VA Strategic Capital Plan and Updated Capital Asset".

Concur Target Completion Date: 10/31/2005

b. Necessary equipment will be obtained, education of staff will be completed and food production will be centralized at Lake City by October 31, 2005. This is dependent on adequate funds being available to implement.

Recommended Improvement Action(s) 2. The Acting VISN 8 Director should require that the System Director obtain eyeglass services through competitive solicitation.

Concur **Target Completion Date:** 03/31/2005

The contract for eyeglass services is between the Veterans Canteen Service (VCS) and a private contractor, not NF/SGVHS. The current contract expired on July 31, 2004. A six month contract extension will be requested by VCS. During these six months NF/SGVHS will competititively solicit an eyeglass contract. We will continue to work with VCS to keep this service in NF/SGVHS facilities for the benefit of our Veterans.

Recommended Improvement Action(s) 3. The Acting VISN Director should require that the System Director conduct a review of OR/SPD inventory and surgical cart procedures to ensure that all systemic problems have been identified and corrective actions taken.

Concur **Target Completion Date:** 01/31/2005

NF/SGVHS is currently seeking VA experts outside this system to perform a complete review of OR/SPD inventory, cart procedures, and related practices to identify all opportunities for improvement and recommend any necessary corrective actions.

Recommended Improvement Action(s) 4. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. Stock levels in GIP are updated and reduced to 30 days supply.

b. Barcoding, scanning, and labeling procedures are implemented to manage all inventory points.

Concur **Target Completion Date:** 08/31/2004

a. Stock levels are being aggressively reviewed and weekly spot checks of inventories are being conducted to increase accuracy rates. Days on hand of stock in the warehouse at the end of April: 26.13, May: 32.69, June: 31.37 and July: 31.97. Days on hand of stock in SPD are consistently below 30 days. Stock levels will be reduced to 30 days by August 31, 2004.

b. Bar coding and inventory of each and every line item as mandated by Ms. Laura Miller is in the process of being implemented. The implementation is currently estimated at 45% complete. Full implementation is expected to be completed by August 31, 2004.

Recommended Improvement Action(s) 5. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. Monthly controlled substances inspections of all locations with controlled substances are performed randomly and unannounced at Gainesville.

b. Controlled substances inspectors use volumetric cylinders to measure liquids during inspections.

Concur **Target Completion Date:** 09/30/2004

a. NF/SGVHS Memorandum 00-10, published May 26, 2004, defines procedures (monthly and unannounced inspections) for controlled substance inspectors. The controlled substance inspectors are responsible for conducting monthly, unannounced inspections ensuring the element of surprise. All Gainesville and Lake City Division inspectors have completed training on this policy. All Satellite Clinic and CBOC inspectors will be educated on this policy by September 31, 2004.

Concur Target Completion Date: 06/01/2004

b. Pharmacy is now equipped with volumetric cylinders to measure liquids. Controlled substance inspectors were educated on this change in procedure.

Recommended Improvement Action(s) 6. The Acting VISN 8 Director should require that the System Director takes action to ensure that:

a. An appropriate business relationship is maintained with pharmaceutical manufacturer representatives.

b. Government ethics rules are enforced.

Concur **Target Completion Date:** 07/01/2004

a. Memorandum No. 119-11 "Business Relationships Between Staff and Pharmaceutical Industry Representatives" was revised on March 5, 2004 and applies to all sites in NF/SGVHS. To ensure compliance, Pharmacy Service provides a copy of the Memorandum to each sales representative and documents with a signed receipt that the Sales Representative has received a copy. This procedure was implemented upon publication of the revised Memorandum on June 7, 2004. Appointments with all providers must be scheduled through Pharmacy Service. Pharmacy monitors the in-service and limits Service inservices (i.e., LTC, Psych, Primary Care, etc) on the same drug once a month.

b. Failure by the Pharmaceutical Representatives to comply with Memorandum 119-11 may result in suspension, limitation, or permanent revocation of visiting privileges as deemed necessary by the Chief, Pharmacy Service.

Recommended Improvement Action(s) 7. The Acting VISN 8 Director should ensure that the System Director takes action to implement a PIN telephone access security system or implements a process to monitor long distance telephone calls to ensure they are appropriate and necessary.

Concur **Target Completion Date:** 01/01/2005

Measures have been taken to mitigate the risks and expense of unjustified long distance calls.

During the installation of all telephone switches, the following outgoing call restrictions are implemented:

International calls are completely blocked.

Local, long distance calls are limited to toll free numbers.

Long distance access is only granted to extensions on an as needed basis by Service.

Phones in public area’s are restricted to in house and local calling area calls only.

In addition, call monitoring capabilities to be utilized include: Telephone switches will be equipped with a call accounting system to audit outgoing calls. The call data recorded will include extension number, date/time, duration of call, route, and trunk number dialed (if outgoing). Data will be recorded on a hard disk within the call accounting system. These reports will be reviewed on a monthly basis for calls more than 30 minutes in length and reported to the appropriate supervisor for review and action. Business Office (Fiscal Service) will also conduct quarterly audits of these reports. This monitoring process was selected in place of implementing a PIN system based on the Cost Benefit Analysis. After monitoring and analysis is complete PINS will be implemented in identified out of control areas.

Recommended Improvement Action(s) 8. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. The VISTA contingency plan is comprehensive and contains key elements to ensure effective contingency planning.

b. Risk assessments are completed for the VISTA and LAN systems.

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

d. Monitoring of employee access to sensitive records is performed regularly and the results are documented.

e. VISTA back-up tapes are stored away from the computer room.

f. Security awareness training is provided to all System staff.

Concur **Target Completion Date:** 05/01/2004

a. The VISTA contingency plan has been modified. Hardware and software configurations and functions are documented in electronic spreadsheets. Key personnel and emergency contact information has been updated and is readily available. A new disaster recovery system has been implemented which permanently records hardware/software configuration on CDs, stored in safe, secure areas in case of disaster.

Concur Target Completion Date: 05/01/2004

b. Risk assessments for the VISTA and LAN systems have been completed.

Concur Target Completion Date: 05/01/2004

c. Quarterly reviews are now conducted to identify accounts not needed. The accounts identified as not needed have been terminated.

Concur Target Completion Date: 05/01/2004

d. Access to sensitive records is now reviewed bi-weekly instead of monthly. Documentation of the reviews and corrective actions taken are now maintained.

Concur Target Completion Date: 05/01/2004

e. VISTA back-up tapes are stored in a secure area away from the computer room and at secure off-site storage facilities.

Concur Target Completion Date: 05/01/2004

f. The ISO reviews cyber security training reports to ensure AIS users receive annual training. Reminders are sent to service chiefs to have personnel complete the annual training. In addition to the online cyber security course, a hardcopy version has been made available for users who cannot complete the online course.

Recommended Improvement Action(s) 9. The Acting VISN 8 Director should ensure that the System Director takes action to ensure that:

a. PT physicians provide timekeepers completed Subsidiary Time and Attendance Reports.

b. Employee Accounts Section staff perform semiannual desk audits of all timekeepers.

Concur **Target Completion Date:** 10/31/2004

a. In March and April 2004 all part time physicians and their timekeepers completed the refresher training entitled "Timekeeper Class Training with Part Time Doctors". The education included acceptable formats of VA Form 4-5631 (employee signatures, approving official signature, timekeeper initials, completed Tour of Duty, completed core time and inappropriate use of abbreviations). All physician leaders will be educated on the acceptable formats of VA Form 4-5631 at the next Medical Executive Committee (MEC), August 25, 2004.

Concur Target Completion Date: 12 /31/04

b. The Employee Accounts Section will complete an internal quarterly desk audit for all part-time physicians timekeepers. The audit will verify posted data, subsidiary record, identify inconsistencies in format and validate signatures/initials were recorded prior to entry into VISTA. Beginning October 2004 quarterly audit reports will be sent to the Compliance & Business Integrity Officer for review.

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Solicit bids and contract directly with a vendor to provide eyeglass services.	$560,000
4a	Reduce stocks to 30-day levels.	92,400
	Total	$652,400

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