Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Durham, North Carolina

Report No. 05-00029-127 **April 22, 2005**

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 October 18–22, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Durham, North Carolina. 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 5 fraud and integrity awareness briefings to 156 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

Results of Review

The CAP review covered 11 operational activities. The medical center complied with selected standards in the following five activities:

- Controlled Substances Accountability
- Emergency Preparedness
- Government Purchase Card Program
- Part-Time Physician Time and Attendance
- Quality Management

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

- Improve controls over environment of care issues.
- Conduct reviews of staffing effectiveness.
- Improve administration of contracts for patient transportation services.
- Improve controls over supply inventory management.
- Improve information technology (IT) security.
- Initiate and complete employee background investigations.

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.

VISN and Interim Medical Center Directors Comments

The VISN and Interim Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 12–21 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Raleigh, Morehead City, and Greenville, North Carolina. The medical center is part of VISN 6 and serves a veteran population of about 191,000 in a primary service area that covers 28 counties in North Carolina and southern Virginia.

Programs. The medical center has 154 hospital beds and 120 nursing home beds and provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center also operates several regional referral and treatment programs, including high-risk open-heart surgery cases, angioplasty, and hemodynamic cardiac catheterization. The medical center also has sharing agreements with Fort Bragg and Duke University Medical Center.

Affiliations and Research. The medical center is affiliated with Duke University Medical Center and supports 132 medical resident positions. In fiscal year (FY) 2004, the medical center's research program had 142 active projects and a budget of $21 million.

Resources. In FY 2004, the medical center's medical care expenditures totaled $209 million. The FY 2005 proposed medical care budget is $219 million. FY 2004 staffing totaled 1,569 full-time equivalent employees (FTE), including 103 physician FTE and 515 nursing FTE.

Workload. In FY 2004, the medical center treated 45,459 unique patients. The medical center provided 42,026 days of inpatient care and 37,122 days of nursing home care. The medical center's inpatient care workload totaled 6,772 discharges, and the average daily census, including nursing home patients, was 217. The outpatient workload was 309,749 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 from our previous CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center Durham, North Carolina*, Report No. 01-01518-30, April 4, 2002).

The review covered medical center operations for FYs 2002 to 2005 through October 22, 2004, 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 11 activities:

Background Investigations	Information Technology Security
Contract Administration	Supply Inventory Management
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Emergency Preparedness	Quality Management
Environment of Care	Staffing Effectiveness
Government Purchase Card Program	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. We made electronic survey questionnaires available to all medical center employees, and 264 employees responded. We also interviewed 43 patients during the review. The survey and interview results were provided to medical center management.

During this review, we also presented 5 fraud and integrity awareness briefings to 156 medical center 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.

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

Results of Review

Opportunities for Improvement

Environment of Care – Patient Safety, Maintenance, and Cleanliness Issues Needed Improvement

Condition Needing Improvement. Several areas of the medical center did not meet safety or environmental standards, and these conditions required management attention:

False Documentation of Defibrillator Checks. In the Critical Care Unit (CCU), nurses falsely documented that they checked the unit's two defibrillators every 8 hours as required by the medical center's crash cart policy. The crash cart check sheets showed that the two defibrillators were checked every 8 hours (for a total of six checks) on October 19 and 20, 2004. However, the paper recordings allegedly supporting the six tests were still in the machines and were dated October 18, 2004. Defibrillators are life-saving equipment that must be maintained in operational order at all times. Untested defibrillators could be malfunctioning, which could result in negative patient outcomes.

Inadequate Number of Defibrillators in Patient Care Areas. There were no defibrillators or automated external defibrillators (AEDs) on the 8th and 9th floors, even though patient care is provided in these areas. Veterans Health Administration (VHA) policy states that AEDs should be considered for locations where there is "a reasonable probability of one AED use in 5 years." A review of cardiac arrest events from 2002 through 2004 showed three code blue events on unit 9B in 2003. While we did not identify any code blue events in the 8th floor clinics (in operation for 2 years), patients receiving care on the 8th and 9th floors do not have the same access to an AED as those receiving care in other areas of the medical center.

Unsecured Medication Refrigerators and Medication Rooms. The Mental Health Primary Care Clinic's medication refrigerator did not have a lock and was located in an unlocked room. In addition, the Hemodialysis unit's two medication rooms were unlocked. VHA policy and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that medications be secured. The lack of medication security could lead to patient harm or theft of medications.

Unlocked Storage Area. Expensive operating room (OR) supplies and equipment were kept in an unlocked storage room. We found boxes of sutures, orthopedic appliances such as replacement femoral heads (used in replacement hip surgery), OR procedure kits, and an endoscopy machine in the room. Unsecured supplies and equipment are vulnerable to theft, which could result in inadequate supplies for OR patients.

Maintenance and Cleanliness of Patient Rooms. Wards 6A, 6B, 7A, 9B, and the Emergency Room waiting room had chipped paint, broken plaster, and malodorous bathrooms. JCAHO requires that patient areas be safe, clean, functional, and comfortable. Ward managers initiated work orders to correct these conditions while we were onsite.

Recommended Improvement Action 1. We recommended the VISN Director ensure that the Interim Medical Center Director requires that: (a) administrative action is taken against the staff who falsely documented defibrillator checks in the CCU; (b) defibrillators are tested as required; (c) defibrillators or AEDs are placed in the 8th and 9th floor patient care areas; (d) medication refrigerators and medication rooms are secured at all times; (e) the OR supply room is secured; and (f) patient rooms, bathrooms, and treatment areas are clean and well maintained.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director reported that action had been taken against the staff who falsely documented defibrillator checks. (In a subsequent email message, the Interim Medical Center Director stated that this action included written counseling and that staff will be provided education on defibrillator testing.) The Nurse Manager makes daily rounds to ensure compliance with defibrillator testing policy, and random audits of crash carts are conducted. AEDs are being acquired for the 8th and 9th floors. Staff received additional education concerning the security of medication rooms and refrigerators, and the OR supply room has been secured. Actions were also taken to ensure the cleanliness of the medical center. We will follow up on the planned actions until they are completed.

Staffing Effectiveness – Reviews Should Be Conducted

Condition Needing Improvement. In FYs 2003 and 2004, medical center managers did not conduct studies to ensure that the number and skill mix of direct and indirect caregivers were sufficient to provide safe, quality care to patients. JCAHO requires Human Resource Management (HRM) Service managers to coordinate the development of indicators, collection and analysis of data, and implementation of appropriate action plans to address staffing variances.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the Interim Medical Center Director requires that HRM Service managers conduct studies to determine if the number and skill mix of direct and indirect caregivers is sufficient to provide safe, quality care to patients.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director reported that the "Staff Effectiveness Report" was presented to the

Executive Committee of the Governing Body at its February 2005 meeting. We will follow up on the planned actions until they are completed.

Contract Administration – Internal Controls for Patient Transportation Services Contracts Needed Improvement

Condition Needing Improvement. The contracting officer's technical representative (COTR) for patient transportation services contracts improperly certified invoices for payment without determining if they complied with contract terms. During FYs 2003 and 2004, the medical center paid about $2.3 million to three vendors for patient transportation services. According to the contracts, the vendors were to be paid a base amount for each trip within the Durham city limits (hired car and wheelchair van services) or within the Durham County limits (ambulance services) plus a mileage charge for all miles traveled outside city or county limits.

We reviewed a sample of 55 trips for the 3 contracts and found that the vendors had incorrectly charged for mileage inside the city or county limits. The vendors charged the medical center the base rate for each trip plus mileage from the point of origin to the destination, thereby inappropriately claiming mileage inside the city or county limits. As shown in the following table, we estimate that the medical center overpaid the vendors about $153,000 for services in FYs 2003 and 2004 and could avoid overpayments of about $76,500 in FY 2005 by ensuring that vendor claims are in accordance with the contract terms:

Review of Patient Transportation Services

Contract	Number Trips Sampled	Excess Miles Claimed	Amount Claimed	Over-payments	Percent Overpaid	FY03 and 04 Payments	Estimated FY03 and 04 Over-payments	Estimated FY05 Over-payments
Hired Car	19	70	$ 836	$ 88	10.5	$ 648,000	$ 68,000	$34,000
Wheelchair Van	19	36	1,336	42	3.1	1,010,000	31,000	15,500
Ambulance	17	176	5,790	516	8.9	607,000	54,000	27,000
Total	**55**	**282**	**$7,962**	**$646**	**8.1**	**$2,265,000**	**$153,000**	**$76,500**

These overpayments occurred because the COTR for the three contracts did not properly review vendor invoices before certifying the invoices for payment. While the contract stated that the Rand McNally Standard Mileage Guide would be used to determine mileage, the guide only showed mileage from the city center to another city center, not the mileage between the Durham city or Durham County limits and the destination. Further, the COTR did not know the location of the city and county limits in order to determine the correct mileage.

Because VISN Consolidated Acquisition Service (CAS) staff awarded the three transportation contracts, we made recommendations to the VISN 6 Director to correct the contract terminology.

Recommended Improvement Action 3. We recommended the VISN Director require that: (a) the CAS staff develops a verifiable payment system with the patient transportation services vendors, and (b) the CAS staff reviews all VISN 6 patient transportation services contracts to identify and collect overpayments.

The VISN 6 Director agreed with the findings and recommendations and stated that guidance was issued to facility Directors regarding their responsibilities concerning reviewing contracts and validating contractors' claims. The Directors were also tasked with counseling COTRs on the importance of their work. In addition, the Financial Quality Assurance Manager was tasked with conducting an audit of all transportation services agreements and to initiating collection actions where appropriate.

Recommended Improvement Action 4. We recommended the VISN Director ensure that the Interim Medical Center Director requires the COTR to verify mileage, in accordance with contract specifications, prior to certifying invoices for payment.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director has taken action to ensure that staff verifies mileage and certifies invoices for payment. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed Improvement

Condition Needing Improvement. The following inventory management areas required management attention:

- Warehouse stock levels exceeded the 30-day supply level.
- Supply Processing and Distribution (SPD) Section inventory records did not contain accurate and complete data.
- Engineering Service had not fully implemented the Generic Inventory Package (GIP).
- SPD staff did not manage the OR ward stock.

The first two conditions were reported in our 2002 CAP report.

VHA policy establishes a 30-day supply level and requires medical facilities to use GIP to establish normal stock levels, set reorder quantities, and track usage of supplies.

Warehouse Inventory. We found that 217 (65 percent) of 334 items in the $232,000 warehouse inventory exceeded the 30-day supply level by about $113,000. This was caused by year-end spending and setting normal stock levels above a 30-day supply level. We sampled 20 items to determine if the inventory balances were correct and normal stock levels were set appropriately. We found that inventory balances were accurately

recorded; however, the normal stock levels for 13 of the items were set at more than a 30-day supply, ranging from 42 days to 2,000 days.

SPD Inventory. GIP inventory records contained inaccurate and incomplete information for SPD's primary inventory control point for medical-surgical supplies.

Our review of 20 sample items showed that the GIP inventory records did not agree with the quantities on hand. We compared our counts for the sampled items with GIP recorded inventory balances and found that the GIP quantities were incorrect for 17 (85 percent) of the 20 items. The GIP values were over reported in 12 instances (less on hand than the recorded inventory) by about $47,500 and under reported in 5 instances (more on hand than the recorded inventory) by about $600.

Our review of SPD's GIP records showed that 94 percent of the 3,168 inventory items exceeded a 30-day supply. However, this data was not sufficient to determine the days of supply on hand because GIP records contained little or no usage data for 1,973 of these items. As a result, we could not reasonably determine the amount of stock on hand that exceeded a 30-day supply.

During FY 2004, the medical center began converting 52 distribution points into the SPD GIP database. However, medical center procedures were not changed to ensure that items were received and issued by SPD and entered into the database. As a result, inventory balances and item usage data were inaccurate and incomplete.

Engineering Inventory. Engineering Service had not fully implemented GIP. Although, Engineering Service entered all items into GIP, they classified them as "recurring use," even though many were "long supply" or "inactive." Engineering Service was maintaining manual inventory records of items received, issued, and on hand. The service was not using the scanning and auto-generation features of GIP to replenish the primary inventory point.

Vendor-Managed Inventory. A vendor managed the $108,000 surgical OR ward stock without SPD review. VA policy requires that all supplies be ordered in a manner that will ensure their availability when needed and keep the total dollar investment in inventory as low as possible. The vendor inventoried and developed reorder requests, and Surgical Service staff purchased the replenishment items. SPD added the items to their primary inventory but did not track them through GIP. SPD management agreed that a 10-day supply level would be sufficient since the inventory is done weekly, the order is made the next day, and the replenishment items are received the following day.

We sampled 15 of 322 stock items and found that normal stock levels were set at more than a 10-day supply, ranging from 11 to 405 days. Based on current stock levels, the value of the sample items was about $5,000. We estimated that if stock levels were set at a 10-day supply, the inventory value for these items could be reduced to about $1,700.

Applying the sample results to the entire surgical OR ward stock inventory, we estimated that the inventory balances could be reduced by about $70,000 (65 percent).

Recommended Improvement Action 5. We recommended the VISN Director ensure that the Interim Medical Center Director requires that: (a) warehouse inventory levels are reduced to the VHA 30-day supply goal, (b) GIP inventory records contain accurate and complete information for SPD's primary inventory control point, (c) Engineering Service fully implements GIP, and (d) medical center staff manages all distribution points and stock levels reflect VHA established supply levels.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director reported that actions have been taken to review inactive lists to identify whether items should be stocked and improve SPD's inventory accuracy. Engineering Service has fully implemented GIP and the contract with the OR ward stock vendor will be terminated and replaced with the new Medical/Surgical Prime Vendor Program. We will follow up on the planned actions until they are completed.

Information Technology Security – Controls Needed Improvement

Condition Needing Improvement. The following automated information systems (AIS) security conditions required management attention:

- AIS certification and accreditation were not current.
- User access and privileges were not monitored.
- Veterans Health Information System and Technology Architecture (VistA), Local Area Network (LAN), and Private Branch Exchange (PBX) contingency plans were not comprehensive.
- The Memorandum of Understanding (MOU) with the alternate processing site did not meet National Institute of Standards and Technology (NIST) security requirements.
- Proper employee background investigations were not initiated.
- Segregation of duties was not outlined in local AIS security policies.
- Computer security awareness training was not provided to all employees.
- Key control was not established for Information Resource Management (IRM) secure areas.

The first two conditions were reported in our 2002 CAP report.

AIS Accreditation and Certification. The Information Security Officer (ISO) had not requested an extension, nor taken all actions required, to obtain AIS accreditation and certification, even though the Interim Authority to Operate had expired on

February 29, 2004. Part of the required action included hiring a contractor to test all major systems.

User Access. The ISO did not perform quarterly reviews of the continued need for AIS access. As of September 23, 2004, the medical center had 1,113 VistA access accounts. Seventy-eight accounts were not accessed in over 90 days, including 32 that had not been accessed in over a year. Three dormant user accounts were reactivated the week before the CAP review without the ISO's approval. One had not been accessed in 10 years. These accounts should be reviewed and action taken to terminate the accounts where appropriate. Quarterly reviews should be performed to identify and terminate accounts that are not needed.

Contingency Plans. Contingency plans did not meet mandatory operational requirements as required by VA. Contingency plans for major operating systems (VistA, LAN, and PBX) identified the VISN 6 headquarters in Durham as the alternate processing site. However, the MOU, dated August 24, 2004, established VA Medical Center Richmond as the alternate processing site. In addition, key personnel after hours telephone numbers were not listed in the plans, and incorrect technical support telephone numbers were listed.

MOU. The MOU with the alternate processing site did not address NIST-required elements, including security and workspace requirements, scheduling, availability, and test time duration.

Background Investigations. Background investigations were not initiated for all employees who participate in the design, operation, or maintenance of sensitive systems. High-risk background investigations were not requested for all IRM staff, which included system administrators for the VistA and LAN systems.

The ISO did not ensure that background investigations had been requested for contract employees before granting them access to sensitive information systems. VA policy states that contract performance shall not commence prior to the initiation of the background investigation process and that contracts must be submitted to the ISO for review and concurrence. Since the ISO did not review and approve contractual agreements, there was no assurance that contracts contained the required provisions on background investigations for contract employees. (See page 12 for discussion of background investigations for other medical center employees.)

Segregation of Duties. Responsibilities for the administration of system access controls and audit trails were not sufficiently segregated. Six system administrators had both administrative rights to access controls and audit trail functions. The AIS security policy did not separate the duties of IT personnel who administer access controls to the medical center's critical resources and those who administer the audit trail functions. VA policy requires that facilities establish policies and procedures to prevent individuals from being responsible for both system access controls and system audit trail functions. The ISO

agreed to limit audit trail administration and to develop policies and procedures to effectively manage administration of system access controls and audit trails.

Computer Security Awareness Training. Computer security awareness training was not provided to all employees. In FY 2004, only 2,390 (78 percent) of the 3,046 users received mandatory computer security awareness training.

Key Control. Key control over all IRM areas was not properly maintained. The telephone technicians had master keys allowing access to all IRM areas. The key coordinator could not account for all IRM keys or identify who had been issued keys. The medical center had installed proximity access readers; however, access could still be obtained using existing keys. Although IRM submitted a work order to re-key the telecommunication closets, the remaining IRM areas needed to be re-keyed to prevent unauthorized access.

Recommended Improvement Action 6. We recommended the VISN Director ensure that the Interim Medical Center Director requires that: (a) all operating systems are properly certified and accredited; (b) the ISO monitors employee continued need for AIS access quarterly and terminates accounts when appropriate; (c) contingency plans are comprehensive and contain key elements to ensure effective contingency planning; (d) the MOU with the alternate processing site meets NIST security requirements; (e) background investigations are initiated for all personnel who participate in the design, operation, or maintenance of sensitive systems; (f) the ISO reviews contracts to ensure that they contain the required provisions regarding background investigations for contract employees; (g) segregation of duties is outlined in the medical center's AIS security policy; (h) annual computer security awareness training is provided to all employees; (i) all IRM areas containing AIS equipment and sensitive data are re-keyed to prevent unauthorized access; and (j) a key control system is established to ensure only authorized personnel access IRM areas.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director reported that VISN 6 had contracted with a security technologies vendor to assist medical facilities in the certification and accreditation of their operating systems and that VHA's contingency plan template will be used to complete system contingency plans. Additionally, the MOU with VAMC Richmond is being reassessed to ensure it meets NIST requirements. The ISO is monitoring employees' continued need for access to AIS, requesting background investigations, reviewing contracts to ensure background investigations are obtained for contract employees when appropriate, and ensuring that staff receive computer security awareness training. Access to the audit trail functions has been changed and duties segregated. IRM space has been secured and key control logs have been created. We will follow up on the planned actions until they are completed.

Background Investigations – Submission and Completion of Investigative Forms Needed Improvement

Condition Needing Improvement. HRM Service staff did not ensure that background investigations were initiated or completed for all current medical center employees. VA policy requires applicants to complete and submit investigative forms, including Fingerprint Card, Questionnaires for Non-Sensitive Positions, and Declarations of Federal Employment within 14 days after they are appointed to nonsensitive/low-risk positions. We found the following:

- Background investigations had not been initiated for 15 current employees whose dates of appointment ranged from September 8, 2002, to September 19, 2004.
- Background investigations had not been completed for 370 (17 percent) of 2,157 current employees (excluding IRM staff and contractors accessing the medical center's computer systems). HRM Service staff had not followed up with the Office of Personnel Management to ensure completion of investigations initiated as far back as August 2003. (See page 10 for discussion of background investigations for IRM staff and contract employees.)

This situation occurred because HRM Service staff had not developed procedures to identify and monitor all employees requiring background investigations.

Recommended Improvement Action 7. We recommended the VISN Director ensure that the Interim Medical Center Director requires HRM Service staff to promptly initiate background investigations and follow up on investigations to completion.

The VISN 6 Director and the Interim Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Interim Medical Center Director reported that all new staff must complete the appropriate forms and will be fingerprinted when they report for initial duty and that a database has been established to track all background investigation requests. We will follow up on the planned actions until they are completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 15, 2005

From: Director, Veterans Integrated Service Network 6 (10N6)

Subject: **VA Medical Center Durham, North Carolina**

To: Director, Office of Inspector General (53B)

Director, Management Review Office (105B)

1. I have reviewed and support the facility's responses to the OIG recommendations 1, 2, and 4-7. Recommendation 3, directed to the VISN, is addressed on the next page.

2. All responses from the Medical Center have been individually addressed and responses inserted directly after each OIG recommendation along with concurrence and target dates as noted.

3. If you have any questions or require further clarification, please contact Alan Begbie, Interim Director, VAMC Durham, via MS Exchange or at (919) 286-6903.

(original signed by:)
Daniel F. Hoffmann, FACHE

VISN Director Comments to Office of Inspector General Report

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

OIG Recommendation(s)

Recommended Improvement Action 3. The VISN Director should require that:

a. The CAS staff develops a verifiable payment system with the patient transportation services vendors.

b. The CAS staff reviews all VISN 6 patient transportation services contracts to identify and collect overpayments.

Concur **Target Completion Date:** September 30, 2005

a. Guidance has been issued to the facilities on January 31, 2005 regarding their responsibilities, which include: review the contract for the agreed upon terms; validate the contractor's claim for mileage using standard mileage program. COTR were directed to disapprove any unsubstantiated claims from the vendor and advise their management of any problematic issues regarding the contract. In addition, each Director has been tasked to provide reinforcement counseling to the COTR's to emphasis the importance of their work. Target Date for counseling is February 18, 2005

b. The Financial Quality Assurance Manager (FQAM) has been tasked to conduct an audit of all transportation agreements and issuing collection actions against those vendors who have overcharged VA for services. Target Date: September 30, 2005

Appendix B

Interim Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 14, 2005

From: Interim Director, VA Medical Center Durham, North Carolina (558/00)

Subject: **VA Medical Center Durham, North Carolina**

To: Director, Office of Inspector General (53B)

Network Director, VA Mid-Atlantic Health Care Network, VISN 6

1. The Veterans Affairs Medical Center Durham appreciated the opportunity to partner with the Office of Inspector General to validate the efforts of the Medical Center in providing high quality health care to our nation's veterans and being good stewards of the public trust. The Recommended Improvements identified have been taken seriously and are actively being addressed or have already been completed.

2. During the site visit, the reviewers commented on several practices that were considered exemplary, as well as, highly positive comments from the patients interviewed. It is unfortunate that these have not been included in this report.

3. If you have any questions or require further clarification, please contact me at (919) 286-6903 or Elizabeth Goolsby, Team Leader, Process and Systems Improvement at (919) 286-6905.

(original signed by:)

ALAN K. BEGBIE

Interim Medical Center Director Comments to Office of Inspector General Report

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

OIG Recommendation(s)

Recommended Improvement Action 1. The VISN Director should ensure that the Interim Medical Center Director requires that:

a. Administrative action is taken against the staff who falsely documented defibrillator checks in the CCU.

b. Defibrillators are tested as required.

c. Defibrillators or AEDs are placed on the 8th and 9th floor patient care areas.

d. Medication refrigerators and medication rooms are secured at all times.

e. The OR supply room is locked to ensure supplies and equipment are secured.

f. Patient rooms, bathrooms, and treatment areas are clean and well maintained.

Concur **Target Completion Date:** FY 2010 (see item f. below)

a. Action was taken against staff that falsely documented defibrillator checks in the CCU. CLOSED.

b. Nurse Manager provided staff education on defibrillator testing to ensure compliance with policy and a mandatory requirement for all staff to review the policy on defibrillator testing. The Nurse Manager conducts daily rounds to ensure compliance with the policy. Process and Systems Improvement conducts random audits on the crash carts verifying compliance with defibrillator checks

every 8 hours and strips ran to support defibrillator checks; results of the audits October 2004 – December 2004 were 100% compliance. CLOSED.

c. The Critical Care Committee evaluated the need for AEDs on the 8th and 9th floors. The Committee determined that there is a reasonable chance that, on average, such a device might be used every 5 years or more often. The decision is proactive not reactive as the three events referred to were not true cardiac arrests but rather medical emergencies of other kinds. AEDs will be acquired for these two areas. TARGET DATE: July 2005

d. Staff has received additional education on the necessity of insuring all medication refrigerators and medication rooms are secured at all times. Nurse Managers round in their areas and correct deficits immediately. Incidences of non-compliance with meeting the intent of the standards in regards to locking medication rooms and refrigerators are addressed with the responsible staff and corrective actions are employed. CLOSED.

e. The long-range plan is to move the supplies and equipment out of the current storage area to an area closer to or in the Operating Room. The short-term plan is to have a keypad lock and automatic closure placed on the door to prevent having unsecured supplies and equipment. TARGET DATE: September 2005

f. A Task Group was convened to discuss Medical Center cleanliness. An action plan was developed and implemented. The actions include frequent interdisciplinary rounds, improvement of communications between services, and a detailed plan for specific cleaning activities in the clinical areas. The report of malodorous bathrooms was not due to a lack of cleanliness but rather the cleaning solution used did not have a pleasant scent. All of the inpatient wards are scheduled for major renovations starting this Spring and continuing for the next 5 years; minor repairs will continue during the interval. All patient care areas are routinely inspected during Administrative Rounds with any deficiencies found corrected through the work order system within 10 days or sooner. Patient wards and clinic areas have an area maintenance employee assigned to correct problems that

are identified. TARGET DATE: Construction completion FY 2010.

Recommended Improvement Action 2. The VISN Director should ensure that the Interim Medical Center Director requires that HRM Service managers conduct studies to determine if the number and skill mix of direct and indirect caregivers is sufficient to provide safe, quality care to patients.

Concur **Target Completion Date:** February 28, 2005

The Staff Effectiveness Report will be presented to the Executive Committee of the Governing Body at its February 2005 meeting.

Recommended Improvement Action 4. The VISN Director should ensure that the Interim Medical Center Director requires the COTR to verify mileage, in accordance with contract specifications, prior to certifying invoices for payment.

Concur **Target Completion Date:** April 30, 2005

Once the VISN 6 contract for transportation has been amended, verification of mileage and certification of invoices for payment will be changed to comply.

Recommended Improvement Action 5. The VISN Director should ensure that the Interim Medical Center Director requires that:

a. Warehouse inventory levels are reduced to the VHA 30-day supply goal.

b. GIP inventory records contain accurate and complete information for SPD's primary inventory control point.

c. Engineering Service fully implements GIP.

d. Medical center staff manages all distribution points and stock levels reflect VHA established supply levels.

Concur **Target Completion Date:** June 30, 2005

a. Due to end of year budget cut-off in spending, warehouse sales are typically lower in the third month of that quarter

with increased sales seen in the first month of the new quarter, which was the case during the site visit. Inactive lists are reviewed every 90 days to identify specific items with no activity in the prior 90 days. Once done, a determination is made to whether the item should continue to be stocked. Within the next 90 days, the Medical Center will be converting to a National Medical/Surgical Prime Vendor. This will reduce stock levels from the current 30 days to 1 week or less for all the medical/surgical items on contract. This will impact about 80% of the inventory. TARGET DATE: June 30, 2005

b. The Medical/Surgical Prime Vendor Program will positively impact the SPD inventories. CLOSED.

c. Engineering GIP was fully implemented on January 15, 2005. A supply clerk FTEE has been authorized to assist Engineering with the GIP. The employee is expected to be on-duty in late March 2005. TARGET DATE: June 30, 2005

d. The contract with the vendor managing the laparoscopic and suture inventories will not be renewed upon expiration of the existing agreement. Orders are being generated and tracked through the GIP in order to track usage. The Medical/Surgical Prime Vendor Program is expected to positively identify inventory tracking. TARGET DATE: June 30, 2005

Recommended Improvement Action 6. The VISN Director should ensure that the Interim Medical Center Director requires that:

a. All operating systems are properly certified and accredited.

b. The ISO monitors employee continued need for AIS access quarterly and terminates accounts when appropriate.

c. Contingency plans are comprehensive and contain key elements to ensure effective contingency planning.

d. The MOU with the alternate processing site meets NIST security requirements.

e. Background investigations are initiated for all personnel who participate in the design, operation, or maintenance of sensitive systems.

f. The ISO reviews contracts to ensure that they contain the required provisions regarding background investigations for contract employees.

g. Segregation of duties is outlined in the medical center's AIS security policy.

h. Annual computer security awareness training is provided to all employees.

i. All IRM areas containing AIS equipment and sensitive data are re-keyed to prevent unauthorized access.

j. A key control system is established to ensure only authorized personnel access IRM areas.

Concur **Target Completion Date:** September 30, 2005

a. VACO Office of Cyber and Information Security has mandated all systems in the federal Information Security Management Act database be certified and accredited by August 31, 2005. VISN 6 has issued a contract with Delta Security Technologies to assist with this process. Durham expects to be certified by the August date. TARGET DATE: August 2005

b. The Information Security Officer monitors employees continued need for AIS access quarterly and requests Information Resources Management Service to terminate accounts when appropriate. CLOSED.

c. VHA is issuing a new contingency plan template prior to June 2005 that all facilities will use. The template will meet all VA and National Institute of Standards and Technology requirements. TARGET DATE: September 30, 2005

d. Durham has a MOU with the VAMC Richmond to serve each other's alternate site needs. The MOU is being assessed to be sure it meets the NIST security requirements. TARGET DATE: June 30, 2005

e. Quarterly, ISO reviews staff changes, requests appropriate background checks and reviews the status of previous requests and reports the findings to the Medical Center leadership. CLOSED.

f. ISO reviews all contracts she receives to determine the need for background checks and other security needs. However, since contracting is centralized to the VISN level the ISO and Chief Human Resources are often not notified of personnel requiring background investigations or if the required forms have been submitted by the contractor to the Office of Security Investigations or the date investigations are completed. CLOSED.

g. Durham has changed access to the audit trials on the network to only one network administrator, the person in charge of network security. Security duties have been segregated. CLOSED.

h. Monthly the ISO receives a list of all personnel who have been trained in computer security awareness. CLOSED.

i. All IRMS spaces have been equipped with Proximity access control points. Police Service controls access lists. Equipment/telecommunication closets have been re-keyed to limit access. CLOSED.

j. Key control logs have been created. CLOSED.

Recommended Improvement Action 7. The VISN Director should ensure that the Interim Medical Center Director requires HRM Service staff to promptly initiate background investigations and follow up on investigations to completion.

Concur **Target Completion Date:** Completed.

All staff must complete an SF 85 and be fingerprinted as part of in processing when they report for initial duty. The completed forms are forwarded to the Office of Personnel Management within the time frames specified in VA Directive 0710, PERSONNEL SUITABILITY AND SECURITY PROGRAM, dated 09/10/2004. A database has been developed to track all background investigation requests. This database meets the tracking requirements for the Inspector General, the Office of Personnel Management,

the VA Office of Human Resources Management and VISN 6. CLOSED.

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds	Questioned Costs
3b	Recover overpayments to patient transportation vendors.	$76,500	$153,000
5a	Reduce warehouse inventory to a 30-day stock level.	113,000	
5d	Reduce OR ward stock inventory to a 10-day supply.	70,000	
	Total	$259,500	$153,000

OIG Contact and Staff Acknowledgments

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