Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Southern Arizona VA Health Care System Tucson, Arizona

Report No. 05-02007-219 **September 30, 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 June 20–24, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Southern Arizona VA Health Care System, which is part of the Veterans Integrated Service Network (VISN) 18. The purpose of the review was to evaluate selected health care system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided fraud and integrity awareness training to 654 health care system employees.

Results of Review

The CAP review covered 13 operational activities. The health care system complied with selected standards in the following eight activities:

- Accounts Receivable
- Colorectal Cancer Management
- Environment of Care
- Government Purchase Card Program
- Laboratory and Radiology Services
- Medical Care Collections Fund
- Part-Time Physician Time and Attendance
- Quality Management

We identified five activities that needed additional management attention. To improve operations, we made the following recommendations:

- Ensure service contracts are properly awarded and administered.
- Reduce excess medical and prosthetics supply inventories.
- Strengthen equipment accountability controls.
- Strengthen pharmacy inventory controls, controlled substances inspection (CSI) procedures, and security.
- Strengthen information technology (IT) security.

VISN and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–25, for the full text of the Directors' comments.) We will follow up on the

planned actions until they are completed. This report was prepared under the direction of Ms. Janet Mah, Director, and Ms. Pauline Murano, CAP Review Coordinator, Los Angeles Audit Operations Division.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Health Care System Profile

Organization. The health care system provides inpatient and outpatient health care services in Tucson, AZ, and provides outpatient care at community-based outpatient clinics located in Casa Grande, Green Valley, Safford, Sierra Vista, and Yuma, AZ. The health care system, which is part of the VA Southwest Health Care Network, serves a veteran population of about 150,000 in a primary service area that includes 8 southern counties in Arizona and 1 in New Mexico.

Programs. The health care system's 258-bed inpatient facility offers medical, surgical, neurological, psychiatric, geriatric, hospice, and rehabilitation services. The health care system is also the home of VA's Southwestern Blind Rehabilitation Center.

Affiliations and Research. The health care system is affiliated with the University of Arizona and supports 94 medical resident positions. The health care system is also affiliated with several colleges to provide clinical training opportunities for nursing, optometry, and allied health students. In fiscal year (FY) 2004, the health care system's research program had 196 projects and a budget of $4.7 million. Important areas of research include cardiology, diabetes, and valley fever.

Resources. In FY 2004, the health care system's medical care expenditures totaled $191.7 million. The FY 2005 medical care budget was $215.2 million, a 12 percent increase over the FY 2004 budget. FY 2004 staffing was 1,545 full-time equivalent employees (FTE), including 89.9 physician FTE and 294 nursing FTE.

Workload. In FY 2004, the health care system treated 44,205 unique patients, a 4.2 percent increase over FY 2003. Health care system officials attributed the increase to continued population growth in Southern Arizona and the excellent reputation of the health care system. The health care system's inpatient care workload totaled 8,523 discharges, and the average daily census was 216. The nursing home average daily census was 77.2. The outpatient workload was 476,387 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 management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered the following 13 activities:

Accounts Receivable	Laboratory and Radiology Services
Colorectal Cancer Management	Medical Care Collections Fund
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Environment of Care	Quality Management
Equipment Accountability	Service Contracts
Government Purchase Card Program	Supply Inventory Management
Information Technology Security	

The review covered facility operations for FY 2004 to FY 2005 through May 2005 and was done in accordance with OIG standard operating procedures for CAP reviews.

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

As part of the review, we also interviewed 35 patients to survey their satisfaction with the quality of care. We discussed the interview results with health care system managers.

During the review, we presented 5 fraud and integrity awareness briefings to 654 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.

Follow-Up on Previous CAP Recommendation

As part of this review, we followed up on a recommendation from the prior CAP review of the health care system (*Combined Assessment Program Review of the Southern Arizona VA Health Care System*, Report No. 01-01074-101, June 29, 2001). In 2001, we found that the Health Care System Director needed to improve part-time physician time and attendance controls. Our June 2005 CAP review found that the Surgical Care, Clinical Care, Fiscal Service, and QM lines at the health care system had established on-going reviews, monitors, and refresher training to ensure part-time physicians

complied with VA time and attendance policies. The Health Care System Director had adequately addressed the recommendation and condition cited in the prior CAP report.

Results of Review

Opportunities for Improvement

Service Contracts – Contract Award and Administration Requirements Should Be Followed

Conditions Needing Improvement. Health care system contracting officers needed to follow the Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR) in order to protect VA's interests and minimize its risk during the contracting process. At the time of the CAP review, VISN 18 Acquisitions and Materiel Management (A&MM) Service managers were consolidating contracting activities for all VISN 18 facilities, including the health care system, at the VISN. We reviewed the award and administration of 15 health care system contracts worth an estimated $26.3 million and found that improvements were needed in 4 areas.

Required Legal and Technical Reviews and OIG Pre-Award Audits. The FAR and VAAR require that sole-source contracts exceeding $500,000 have legal and technical reviews and an OIG pre-award audit. The FAR and VAAR only require legal and technical reviews by the VA Office of Acquisition and Materiel Management for competitive contracts if the contracts exceed $1.5 million. Of the 15 contracts reviewed, 2 sole-source contracts valued at $3.1 million did not have the required OIG pre-award audits. Also, one of the sole-source contracts (value = $1.1 million) and a competitive contract (value = $2.2 million) had not been submitted for the required legal and technical reviews. If the required OIG pre-award audits had been completed for the two sole-source contracts, the health care system could have saved as much as $406,015 over the life of the contracts.[1]

Contract Requirements and Documentation. The FAR requires contracting officers to ensure that contract prices are fair and reasonable and to establish contract terms and conditions that protect the Government's interests. It also requires contracting officers and Contracting Officer's Technical Representatives (COTRs) to effectively manage and monitor contract performance.

- Two Basic Order Agreement contracts (BOAs) valued at $657,000 for community nursing home and substance abuse treatment services were not awarded in

[1] The OIG determined that pre-award audits result in potential average savings of 21 percent of the proposed contract prices and that 62 percent of the potential savings is sustained during contract negotiations. Applying these percentages to the total estimated value of the two contracts resulted in an estimated savings of $406,015 ($3,118,391 x 21 percent x 62 percent).

accordance with the FAR.[2] The BOAs did not have: (1) required order limitations or total dollar thresholds in the contracts' terms and conditions; (2) price negotiation memorandums (PNMs) that addressed areas such as the Government's negotiation objective, the basis for determining price reasonableness, and supporting documentation for the fairness and reasonableness of contract prices; and (3) evidence of the contractors' medical liability insurance or a pre-award facility survey to show that the contractors met the Government's safety and liability requirements.

- A sole-source ambulance services contract valued at $124,000 did not have the required sole-source justification or PNM.
- A sole-source janitorial services contract that had not been submitted for OIG pre-award audit did not have sufficient market research needed to establish current commercial janitorial services prices to validate the fairness and reasonableness of offered contract prices.
- A sole-source prosthetics contract, a competitive radiopharmaceutical contract, and a BOA for substance abuse treatment valued at about $2 million did not identify health care system staff authorized to place orders on the contracts. In the case of the $1.6 million radiopharmaceutical contract, Nuclear Medicine Service staff who were not identified in the contract as being authorized to do so ordered items valued at $45,550.

Contract Administration. The FAR requires Government employees to administer and execute contracts in accordance with written terms and conditions established by the contracting officer during the contracting process.

- At the time of the CAP review, health care system staff were obtaining radiation and oncology services from the affiliated university even though the $2 million contract with the university had expired in December 2004. According to the A&MM Service Manager, the affiliated university refused to sign an interim contract because negotiations were underway on a new contract.
- The health care system's Laboratory Service provided laboratory tests that were not part of the $1.2 million contract to sell laboratory services to the affiliated university. Although $19,900 was collected for the completion of these tests, the health care system could not ensure that it had received fair and reasonable compensation for these tests because the charges had not been negotiated as part of the contract.

COTR Delegations and Training. The VAAR requires COTRs to sign delegation letters prepared by the contracting officers that define the scope of responsibilities delegated to

[2] A BOA is a negotiated contract that includes: (1) the applicable terms and conditions for the ordering of services and supplies during the specified award period; (2) a description of supplies or services to be provided; and (3) methods for pricing, issuing, and delivering the future supply and service orders.

the COTRs. Since November 1999, VA has also required COTRs to attend training on their responsibilities to effectively monitor contract performance and approve payments. Of the 16 COTRs who administered the 15 contracts reviewed, 7 had not signed delegation letters, and 2 had not received the required training. In addition, two COTRs – one who had attended the required training and one who had not – allowed health care system staff to order items and provide services that exceeded the scope of the awarded contracts.

Recommendation 1. We recommended that the VISN Director require contracting officers to: (a) obtain required legal and technical reviews and OIG pre-award audits for competitive and sole-source contracts; (b) ensure all applicable FAR and VAAR requirements are met; (c) ensure services are obtained through valid contracts and contracts are properly administered; and (d) ensure COTRs sign delegation letters, receive formal COTR training, and effectively monitor and manage contract compliance.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that the Contracting Manager will review all sole source or competitive procurements to ensure required OIG pre-award audits or legal and technical reviews are completed, monitor compliance with Office of Acquisition and Materiel Management Business Review checklists containing applicable FAR and VAAR requirements, monitor contract expiration dates, and ensure contracting officers meet with COTRs quarterly to monitor contract compliance. Furthermore, the Supply Manager and the Associate Director will monitor the Contracting Manager's activities to ensure these requirements are met. As of August 26, 2005, all COTR delegation letters had been signed and all COTRs had received formal training. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Excess Inventories Should Be Reduced

Conditions Needing Improvement. A&MM Service and Prosthetics Program managers needed to reduce excess medical and prosthetic supplies and manage supply inventories more effectively. Veterans Health Administration (VHA) policy establishes a 30-day supply goal and requires medical facilities to use VA's automated Generic Inventory Package (GIP) to manage their medical supply inventory. A&MM Service and Prosthetics Program managers should use GIP and the Prosthetics Inventory Package (PIP) to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and conduct physical inventories. We selected a judgment sample of 35 medical and 10 prosthetics supply line items and found that GIP inventory records were accurate in a comparison of the actual quantities on hand with the quantities reported in the records. However, improvements were needed in two areas.

Excess Medical Supply Inventory. As of June 20, 2005, the medical supply inventory had 1,894 line items valued at $613,720 located in 10 primary inventory distribution

points. Four of the 10 primary inventory distribution points, which had 1,516 line items valued at $409,965, had been operational for over a year and had reliable historical usage data. Our review of the inventory levels of these 4 primary inventory distribution points disclosed that 1,064 (70 percent) of the 1,516 medical supply line items had inventory that exceeded the 30-day supply goal. The excess inventory totaled $197,361, or 48 percent of the total value of the inventory at the four reviewed inventory distribution points. According to the A&MM Service managers, the excess inventory developed because of the vendors' minimum order requirements for certain supplies and the stocking of duplicate items at multiple primary inventory distribution points.

Excess Prosthetic Supply Inventory. As of June 23, 2005, the Prosthetics Program maintained an inventory of 492 supply items valued at $402,680. The quantities of prosthetics supplies reported in PIP accurately reflected the quantities of supplies on hand. However, the inventory for 484 (98 percent) of the 492 prosthetic line items exceeded the 30-day supply goal. The excess inventory totaled $339,997, or 84 percent of the total prosthetics inventory. According to the Prosthetics Program Manager, the excess inventory developed during the tenure of the prior manager who did not monitor supply usage and adjust reorder quantities.

Recommendation 2. We recommended that the VISN Director ensure that the Health Care System Director requires that A&MM Service and Prosthetics Program staff monitor item usage rates, adjust inventory levels, and reduce excess supply inventories.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that efforts to reduce excess inventories are ongoing. A&MM Service staff are reducing supply inventories to comply with the 30-day supply inventory, and Prosthetics Program staff have implemented new procedures to control the ordering and issuance of stock. The health care system's prosthetics inventory has decreased 25 percent since the CAP review. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Controls Needed To Be Strengthened

Conditions Needing Improvement. The A&MM Service Supply Manager needed to improve procedures to properly safeguard and account for non-expendable equipment (items that are sensitive and acquired for more than $5,000 with an expected useful life of more than 2 years). VA policy requires the completion of periodic inventories to ensure equipment is properly accounted for and recorded on Equipment Inventory Lists (EILs). As of May 2005, the health care system had 154 EILs containing 9,545 items, valued at $57.9 million. We reviewed a judgment sample of 30 equipment items, valued at $113,007, selected from 5 EILs and identified 4 areas which needed improvement.

Reports of Survey. VA policy requires health care system staff to prepare "Reports of Survey" (ROS) and submit them to A&MM Service when Government property is

missing, damaged, or destroyed. From January 2004 through May 2005, health care system staff submitted 1,213 ROS for missing equipment, valued at $4.3 million, to A&MM Service. A&MM Service submitted the ROS to the health care system's Police Service for investigation. However, A&MM Service did not forward the ROS to the Health Care System Director as required when property losses exceeded $5,000, so that independent boards could be convened to investigate the losses. Of the 1,213 ROS which were submitted to A&MM Service, 159 had losses which exceeded $5,000. The Health Care System Director was not aware of the amount of missing equipment or the 159 ROS which required board investigations until we identified the problem during the CAP review. As of June 24, 2005, the A&MM Service Supply Manager still had not forwarded the ROS to the Health Care System Director.

Inaccurate EIL Information. A&MM Service staff did not accurately record EIL equipment information as required by VA policy. Radiology Service's March 2005 EIL contained a listing for a single computer valued at $1,091,330 when the equipment should have been recorded as 10 computer workstations valued at $109,133 each. The A&MM Service Supply Manager stated that inexperienced A&MM Service staff improperly recorded these items.

EIL Inventories. VHA policy requires health care system staff to complete EIL inventories within 10 days of notification (20 days if the EIL contains 100 or more items) and requires A&MM Service staff to send delinquency notices to responsible officials when inventories are overdue. In addition, the A&MM Service Supervisor is required to notify the Health Care System Director of the delinquent inventories. Under VHA policy, the Health Care System Director is the only official authorized at the health care system to grant extensions for delinquent inventories. Of the 154 EIL inventories which were due by May 2005, 31 (20 percent) had not been completed at the time of the CAP review. According to the A&MM Service Supply Manager, A&MM Service did not promptly send delinquency notices to the officials responsible for the delinquent EIL inventories because of a staffing shortage and a lack of qualified A&MM Service staff. In addition, the A&MM Service Supervisor did not notify the Health Care System Director of the delinquent inventories and granted extensions for the completion of the inventories. Subsequently, A&MM Service did not initiate any delinquency notices until May 2005, 1 month before the start of the CAP review.

Quarterly Spot Checks. VA policy requires A&MM Service to conduct quarterly spot checks of all EILs to verify inventory accuracy. From October 1, 2004, through May 31, 2005, A&MM Service staff did not perform any quarterly spot checks. Instead, they performed spot checks of EILs only after the responsible officials completed their EIL inventories. The A&MM Service Supply Manager stated that he was unaware that VA policy required A&MM Service to perform quarterly spot checks.

Recommendation 3. We recommended that the VISN Director ensure that the Health Care System Director requires that A&MM Service:

a. Forward required ROS forms to the Health Care System Director.
b. Accurately record information on EILs.
c. Ensure that responsible staff complete EIL inventories within the proper timeframes.
d. Promptly send delinquency notices to the responsible officials for overdue EIL inventories.
e. Promptly notify the Health Care System Director of the delinquent EIL inventories and ensure that extensions are authorized only by the Health Care System Director.
f. Conduct quarterly spot checks of EILs to verify inventory accuracy.

The VISN and Health Care System Director agreed with the finding and recommendations and reported that the health care system has accounted for all but $47,498 of the $4.3 million in equipment that was originally reported missing. To ensure equipment accountability problems do not recur, the Health Care System Director has authorized additional staff for the equipment management section and reorganized A&MM Service. Staff have been specifically dedicated to the timely processing and recording of equipment turn-ins to ensure turned-in excess equipment items are not erroneously reported as missing. By September 30, 2005, the health care system plans to issue standard operating procedures to ensure delinquency notices are issued for overdue EIL inventories, delinquent EIL inventories are reported to the A&MM Service Supply Manager and the Health Care System Director, only the Health Care System Director grants extensions for delinquent inventories, and A&MM Service staff conduct quarterly inventory spot checks. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Pharmacy Service – Inventory Management, Controlled Substances Inspections, and Security Needed Improvement

Conditions Needing Improvement. The Pharmacy Service Manager and the Controlled Substances Coordinator (CSC) needed to improve inventory management controls, CSI procedures, and pharmacy security. Required 72-hour controlled substances inventories were performed, and controls over controlled substances maintained in Research Service were effective. However, we identified three areas that needed improvement.

Pharmaceutical Inventory Controls. VHA policy requires Pharmacy Service to perform an annual wall-to-wall physical inventory of all pharmaceuticals to ensure the accuracy of inventory records and to assist in the prevention and detection of diversion. From 2002 to 2005, Pharmacy Service staff did not conduct two of the four required physical inventories because the Pharmacy Service Manager was not aware they were required annually.

Controlled Substances Inspector Training and Appointment. VHA policy requires the health care system's CSC to ensure all controlled substances inspectors receive CSI training. It also requires the Health Care System Director to appoint all controlled substance inspectors in writing. Three (7 percent) of the health care system's

41 controlled substances inspectors did not attend required CSI training and had not been appointed in writing by the Director. In addition, one inspector completed two inspections prior to receiving training. To ensure the effective operation of the health care system's CSI program and to assist in the prevention and detection of diversion, controlled substances inspectors need to complete CSI training before conducting inspections.

Pharmacy Security. General pharmacy security needed to be strengthened. An unescorted OIG auditor, who had not been previously introduced to the Pharmacy Service staff, was allowed access throughout the inpatient pharmacy area without being questioned. When the auditor requested entrance into the pharmacy, the door was unlocked using a remote device, and Pharmacy Service staff did not verify the auditor's identity or provide an escort. On two separate occasions, a health care system delivery person and a researcher who were not employed within the pharmacy gave the auditor access to the pharmacy. VA policy and local pharmacy operating procedures require access to the pharmacy be tightly controlled. Unescorted visitors in the pharmacy area present many security risks, including the potential diversion of pharmaceuticals. Also, the outpatient vault did not have a VA-required motion detector inside because it had been installed, in error, on the outside of the vault.

Recommendation 4. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) the Pharmacy Service Manager ensure that a wall-to-wall physical inventory of all pharmaceuticals is completed annually, (b) all controlled substances inspectors receive CSI training before they conduct inspections, and (c) the Pharmacy Service Manager ensures that the pharmacy's physical security complies with VA policy.

The VISN and Health Care System Director agreed with the finding and recommendations and reported that a wall-to-wall inventory would be conducted in May 2006 and on an annual basis thereafter. All inspectors will be trained by October 1, 2005, and those who have not yet been trained, will not be allowed to conduct inspections until after the training is completed. All Pharmacy Service staff have certified that they have reviewed the pharmacy's standard operating procedures on security, including the process for allowing non-pharmacy staff and visitors into the pharmacy, and this process has been incorporated in the orientation process for all new pharmacy staff. Also, a motion detector was installed inside the outpatient pharmacy vault. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Security Controls Should be Strengthened

Conditions Needing Improvement. The Information Security Officer (ISO) and the Information Resources Management (IRM) Service Manager needed to strengthen IT controls. VA policy requires health care systems to establish, maintain, and enforce a comprehensive information security program to ensure adequate levels of protection are in place for all health care system information security systems. These control measures protect IT assets and sensitive information from unauthorized access, disclosure, modification, destruction, or misuse, as well as continuance of business operations following disruption or disaster. While health care system controls over application software and system software were adequate, five areas still needed improvement.

Continuity of Business Operations. The ISO had not completed and tested the health care system's comprehensive Automated Information System (AIS) contingency plan for its alternate AIS processing site. VA policy and VHA directives require health care systems to have contingency plans in place that allow for the recovery of IT services and ensure the continuity of business operations in the event of a disruption or disaster. During our prior CAP review in 2001, the health care system did not have comprehensive written AIS contingency plans that addressed its major computer systems, alternative AIS processing site, and system restoration priorities. After the 2001 CAP review, the ISO developed contingency plans to address these three findings. The contingency plans addressing the disruption of major computer systems and system restoration priorities were adequate. However, the alternate AIS processing site plan was incomplete, failing to provide adequate logistical details for the relocation. Although the plan designated the Carl T. Hayden VA Medical Center in Phoenix, AZ, as the alternate AIS processing site, the health care system still had not completed the plan's logistics or tested it as of June 24, 2005.

Local Area Network Access. Safeguards to restrict unauthorized access to the local area network (LAN) needed to be strengthened. To prevent misuse and preserve the LAN's integrity, VHA requires LAN access to be controlled and limited through the use of user identifications and passwords. The ISO and IRM Service staff enforced strong password requirements and had implemented intruder lockout features that suspended accounts after three failed logon attempts. However, we observed that unattended computers were left logged on to the LAN when users left their workstations. The IRM Service Manager and ISO had not implemented any monitoring procedures or automated security measures to ensure inactive computers were logged off the LAN.

Internet Monitoring. The IRM Service Manager and ISO had not established a process for monitoring or measuring Internet usage for the health care system's 1,748 employees as required by VA policy. Improper Internet usage can lead to loss in productivity, increased network costs, and the investment of significant resources to correct related

system and network configuration problems. IRM Service staff did not have procedures to monitor personal Internet usage and relied on health care system supervisors to notify the ISO of any unauthorized or improper activity.

Segregation of Duties. The Health Care System Director had not established local policy or procedures to ensure the segregation of incompatible IT duties. VA policy requires a health care system to establish controls to ensure individuals are not assigned IT duties that would allow them to conduct unauthorized actions or gain unauthorized access to IT systems. At the time of the CAP review, the health care system had not developed a policy that identified which positions or IT duties needed to be segregated and what procedures were to be followed to ensure that these positions or duties were properly segregated.

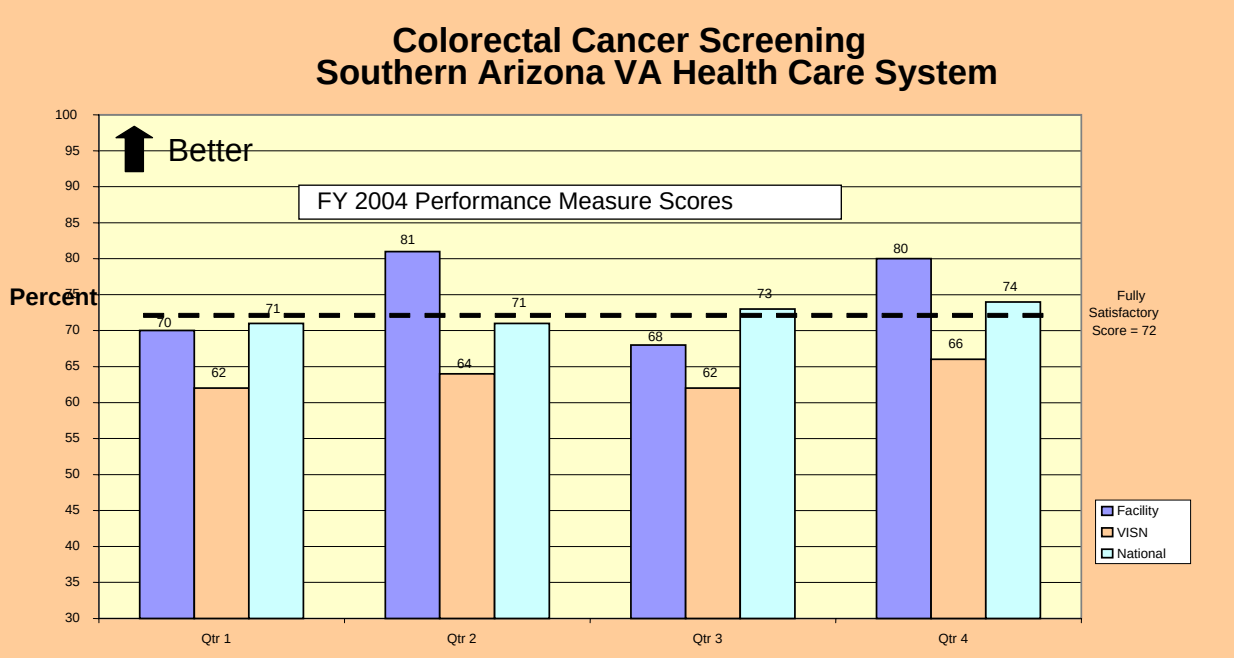
ISO Position. The ISO is responsible for developing, implementing, and monitoring a facility's information security systems. VHA policy requires the ISO to be a full-time position only at larger facilities. Because the Health Care System Director wanted the ISO to also manage the health care system's CSI program, he assigned the ISO the CSC's duties. The ISO estimated that the CSI program accounted for 25 percent of his workday and believed that these additional duties along with the size and complexity of the health care system affected his ability to perform his ISO duties.

Recommendation 5. We recommended that the VISN Director ensure that the Health Care System Director: (a) completes and tests the contingency plans for relocating AIS operations to the alternate AIS processing site, (b) implements additional safeguards to prevent unauthorized LAN access when computers are unattended, (c) requires the IRM Service Manager and ISO establish a process for monitoring Internet usage, (d) develops local policy for the segregation of incompatible IT duties, and (e) adjusts the ISO's responsibilities to ensure he is able to adequately carry out the health care system's ISO functions.

The VISN and Health Care System Director agreed with the finding and recommendations and reported that a test of the alternate processing site will be conducted once the policies have been developed for the test. In addition, safeguards will be implemented to restrict LAN access on unattended computers, monitoring will be initiated for improper Internet usage, and policies and procedures will be developed to ensure the segregation of incompatible duties. By October 1, 2005, another health care system staff person will assume responsibility for the CSI program and allow the ISO to return to his full-time information security responsibilities. The improvement plans are acceptable, and we will follow up on the planned actions until they are complete.

Other Observations

Colorectal Cancer Management Processes Were Timely and Appropriate. The health care system's colorectal cancer screening performance and our assessment of colorectal cancer management during the CAP review disclosed that care was timely and appropriate. The health care system's colorectal cancer screening performance at the end of FY 2004 met VHA's performance measure which assesses the percent of patients screened within prescribed timeframes. We conducted a judgment sample of 10 patients diagnosed with colorectal cancer and disclosed that health care system staff had provided timely Gastroenterology, Hematology/Oncology, and Surgery consultative and treatment services; promptly informed patients of diagnoses and treatment options; and developed coordinated interdisciplinary treatment plans. This level of care is essential to the early detection, appropriate management, and the achievement of optimal outcomes for patients diagnosed with colorectal cancer. The following tables contain the results of our review.



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Patients appropriately screened	Patients diagnosed within a reasonable timeframe	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatments
10/10	9/10	10/10	10/10	10/10

Patients Reported High Satisfaction with Care and Services. Our interviews of 35 patients and the health care system's scores on VHA's Survey of Health Care Experiences of Patients (SHEP) indicated that patients were highly satisfied with care and services at the health care system. For example, 100 percent of the patients we interviewed would recommend care at the health care system to an eligible family member or friend. Also, 94 percent rated the quality of care as excellent or very good, and over 94 percent generally felt they were involved in decisions about their care. Also, from October 2004 to March 2005 the health care system reported an average SHEP score of 81 percent for overall quality compared to the national average of 77 percent.

Appendix A

VISN 18 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 8, 2005

From: Network Director, VISN 18 (10N18)

Subject: **Southern Arizona VA Health Care System Tucson, Arizona (678)**

To: Office of Inspector General

I have reviewed and support the facility's responses to the CAP recommendations, which have been individually addressed in the attached document. The facility Director has completed many of the actions and has outlined acceptable action plans for the remaining open items.

Patricia A. McKlem

Attachment

VISN 18 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 Recommendations

Recommendation 1. We recommend that the VISN Director require contracting officers to: (a) obtain as required legal and technical reviews and OIG pre-award audits for competitive and sole-source contracts; (b) ensure all applicable FAR and VAAR requirements are met; (c) ensure services are obtained through valid contracts and contracts are properly administered; and (d) ensure COTRs sign delegation letters, receive formal COTR training, and effectively monitor and manage contract compliance.

Concur **Target Completion Date: Closed**

See facility Director comments.

Recommendation 2. We recommend that the VISN Director ensure that the Health Care System Director requires that A&MM Service and Prosthetics Program staff monitor item usage rates, adjust inventory levels, and reduce excess supply inventories.

Concur **Target Completion Date: 12/31/05**

See facility Director comments.

Recommendation 3. We recommend that the VISN Director ensure that the Health Care System Director requires that A&MM:

a. Forward required ROS forms to the Health Care System Director.
b. Accurately record information on EILs.
c. Ensure that responsible staff complete EIL inventories within the proper timeframes.

d. Promptly send delinquency notices to the responsible officials for overdue EIL inventories.
e. Promptly notify the Health Care System Director of the delinquent EIL inventories and ensure extensions are authorized by the Health Care System Director.
f. Conduct quarterly spot checks of EILs to verify inventory accuracy.

Concur **Target Completion Date: 9/30/05**

See facility Director comments.

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the Pharmacy Service Manager ensure that a wall to wall physical inventory of all pharmaceuticals is completed annually, (b) all inspectors receive CSI training before they conduct inspections, and (c) the Pharmacy Service Manager ensures that the pharmacy's physical security complies with VA policy.

Concur **Target Completion Date:** 10/1/05

See facility Director comments.

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director: (a) completes and tests the contingency plans for relocating AIS operations to the alternate AIS processing site, (b) implements additional safeguards to prevent unauthorized LAN access when computers are unattended, (c) requires the IRM Service Manager and ISO establish a process for monitoring Internet usage, (d) develops local policy for the segregation of incompatible IT duties, and (e) adjusts the ISO's responsibilities to ensure he is able to adequately carry out the health care system's ISO functions.

Concur **Target Completion Dates:** (a) 12/31/05
(b) 11/1/05
(c) 11/1/05
(d) 11/30/05
(e) 10/1/05

See facility Director comments.

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 7, 2005

From: Southern Arizona VA Health Care System Director

Subject: **Southern Arizona VA Health Care System Tucson, Arizona**

To: Office of Inspector General

Thru: VISN 18 Director

Attached, please find our response to the Combined Assessment Program (CAP) review of the Southern Arizona VA Health Care System conducted June 20 – 24, 2005.

If you have any questions or comments, you can reach Mr. Spencer Ralston, Associate Director, at (520) 629-1821.

Sincerely,

Jonathan H. Gardner, FACHE

Health Care 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 Recommendations

Recommendation 1. We recommend that the VISN Director require contracting officers to: (a) obtain as required legal and technical reviews and OIG pre-award audits for competitive and sole-source contracts; (b) ensure all applicable FAR and VAAR requirements are met; (c) ensure services are obtained through valid contracts and contracts are properly administered; and (d) ensure COTRs sign delegation letters, receive formal COTR training, and effectively monitor and manage contract compliance.

(a) **Concur**. The Supply Manager shall require the Contracting Manager to personally review each requirement initiated for supplies and services, sole-source or competitive, that is estimated to exceed the threshold for legal-technical review or OIG pre-award audit. Additionally, the Supply Manager shall meet with the Contracting Manager to review contracting activity on a weekly basis, and the Associate Director shall monitor compliance with this requirement.

Target Completion Date: Currently in place. Closed.

(b) **Concur**. The Supply Manager shall require the Contracting Manager to implement the consistent use of, and monitor the compliance with, the OA&MM Business Review checklists. Additionally, the Supply Manager shall meet with the Contracting Manager to review contracting activity on a weekly basis, and the Associate Director shall monitor compliance with this requirement.

Target Completion Date: Currently in place. Closed.

(c) **Concur**. The Supply Manager shall require the Contracting Manager to review the automated VISN contract log, on a monthly basis, to monitor contract expiration dates, and to initiate appropriate action to ensure continued contract coverage, if such coverage is still necessary. Additionally, the Supply Manager has already required the Contracting Manager to instruct all contracting officers to meet on a quarterly basis with all technical representatives to monitor contract compliance. Contract expiration and contract administration shall be a topic of the weekly meeting between the Supply Manager and the Contracting Manager, and the Associate Director shall monitor compliance.

Target Completion Date: Currently in place. Closed.

(d) **Concur**. As of August 26, 2005, all COTR delegation letters have been signed and all COTRs have received formal training. Monitoring and management of contract compliance shall be achieved through the regular quarterly CO/COTR meetings and as circumstances dictate.

Target Completion Date: August 26, 2005. Closed.

Recommendation 2. We recommend that the VISN Director ensure that the Health Care System Director requires that A&MM Service and Prosthetics Program staff monitor item usage rates, adjust inventory levels, and reduce excess supply inventories.

A&MM Response: **Concur**. A&MM will draw down supply inventories, for the 12 primary inventory points, to a less than 30-day supply, cumulatively, in accordance with VHA standards in VHA Handbook 1761.2. With implementation and expansion of the med/surg prime vendor, minimum order quantities will have less of an impact on days of stock on hand, and will facilitate achievement of the draw down of supply levels. Efforts to reduce excess supply inventories have been ongoing and shall continue.

Target Completion Date: December 31, 2005.

Prosthetics Response: **Concur**. The Prosthetics staff has removed excess stock and has now implemented a new

procedure for both ordering and issuing of stock items. The stock levels were reviewed and adjusted accordingly to ensure excess stock would not be ordered in the future. The Prosthetic Barcode Program has been implemented to provide tighter control over stock on hand and to ensure accurate issuance of items. A new ordering method has been implemented to correspond with the stockroom inventory placement. This system allows accurate count of stock on hand, shows levels to maintain and enables the inventory manager to make accurate determination of stock needs. As needs change, the stock levels will be adjusted accordingly. The current prosthetic inventory has already been decreased by 25% since the CAP survey. The NPPD variance report for July 05 was at 1.49%, which is less than the national goal of 2.0%.

Target Completion Date: December 31, 2005.

Recommendation 3. We recommend that the VISN Director ensure that the Health Care System Director requires that A&MM:

a. Forward required ROS forms to the Health Care System Director.
b. Accurately record information on EILs.
c. Ensure that responsible staff complete EIL inventories within the proper timeframes.
d. Promptly send delinquency notices to the responsible officials for overdue EIL inventories.
e. Promptly notify the Health Care System Director of the delinquent EIL inventories and ensure extensions are authorized by the Health Care System Director.
f. Conduct quarterly spot checks of EILs to verify inventory accuracy.

(a) **Concur**. It is important to note that the large volume of backlogged ROS was due to the recent activation of a clinical addition major construction project, and failure of the responsible staff member to follow hospital policy regarding the proper processing of turned-in equipment. That employee was subsequently terminated, and a wall-to-wall survey of all equipment was conducted. This survey resulted in an even heavier volume of ROS. This large volume was under review by the Supply Manager prior to sending to the Director at the

time of the OIG CAP review. The value of the missing equipment stated by the OIG, $4.3 million, was the original acquisition value of the equipment, but our subsequent review found that the depreciated value was $1.4 million. Following the CAP review, the Health Care System Director ordered a review of all outstanding reports of survey. Every one of the "missing items" identified by the OIG CAP review with an original acquisition value greater than $5,000 was found. Further, as of August 29, 2005, SAVAHCS had accounted for virtually all items; an unaccounted-for balance of only $47,498 (original acquisition value), or $33,331 (depreciated value) remains unresolved. Work continues on the small number of remaining unaccounted-for items. This process revealed that many of the items reported on the ROS were, in fact, still in-house, and in service. Some items had been turned-in, but not properly recorded. Some items had been disposed of through small lot sales, and not properly recorded. Other items had been traded-in with the purchase of new equipment, and not properly recorded. The Health Care System Director has authorized additional staffing resources to prevent a recurrence of equipment turn-in backlogs. Additionally, he has directed a review and revision of the existing equipment turn-in policy, as well as the procedure for the proper and timely notification to management for applicable reports of survey.

Target Completion Date: September 30, 2005

(b) **Concur**. The Health System Director authorized additional staff for the equipment management section, and the materiel management section is being reorganized to allow the Supervisory Supply Management Specialist more time to devote to the training and oversight of staff in this section. **Target Completion Date:** September 30, 2005.

(c) **Concur**. The Supply Manager shall develop a Standard Operating Procedure (SOP) for the equipment management staff requiring they notify the Supply Manager when any EIL has not been acted upon within 5 days of the initial notification to the responsible office and alternate responsible official that an inventory is due to be conducted.

Target Completion Date: September 30, 2005.

(d) **Concur**. The Supply Manager shall include in the SOP that the Supervisory Materiel Management Specialist issue delinquency notices immediately upon expiration of the time allotted for conduct of the inventory.

Target Completion Date: September 30, 2005.

(e) **Concur**. The Supply Manager shall include in the SOP that the Health Care System Director be informed of any EIL that becomes delinquent. Additionally, the SOP shall state that only the facility director may approve an extension.

Target Completion Date: September 30, 2005.

(e) **Concur**. We now believe we have a satisfactory procedure in place, as evidenced by the fact that during the CAP survey, the OIG randomly selected 30 pieces of equipment to spot check, and located all 30 pieces of equipment. However, we will still implement spot checks as recommended by the OIG through the implementation of a materiel management section Standard Operating Procedure.

Target Completion Date: September 30, 2005

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the Pharmacy Service Manager ensure that a wall to wall physical inventory of all pharmaceuticals is completed annually, (b) all inspectors receive CSI training before they conduct inspections, and (c) the Pharmacy Service Manager ensures that the pharmacy's physical security complies with VA policy.

(a) **Concur**. A wall to wall inventory was conducted in May 2005 and is scheduled again for May 2006, and will be scheduled on an annual basis thereafter.

Target Completion Date: Closed.

(b) **Concur**. Those few remaining inspectors who have not completed training will have done so by October 1. Until then, they will not conduct inspections.

Target Completion Date: October 1, 2005

(c) **Concur**. All pharmacy staff has verified in writing that they have read the pharmacy standard operating procedure memorandum on security, which includes the process that must be followed for providing pharmacy access to non-pharmacy staff and visitors. This verification has been incorporated into the orientation process for all new pharmacy employees. A motion detector was installed inside the outpatient pharmacy vault prior to the departure of the CAP surveyors.

Target Completion Date: Closed.

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director: (a) completes and tests the contingency plans for relocating AIS operations to the alternate AIS processing site, (b) implements additional safeguards to prevent unauthorized LAN access when computers are unattended, (c) requires the IRM Service Manager and ISO establish a process for monitoring Internet usage, (d) develops local policy for the segregation of incompatible IT duties, and (e) adjusts the ISO's responsibilities to ensure he is able to adequately carry out the health care system's ISO functions.

(a) **Concur**. The IRM Service Line, in conjunction with the VISN Information Technology Office, will develop policies and test the functionality of an alternate processing site for business continuity in the event of a disaster.

Target Completion Date: December 31, 2005.

(b) **Concur**. The ISO and IRM Service Line will develop safeguards to automatically restrict access of unattended computers.

Target Completion Date: November 1, 2005.

(c) **Concur**. Internet monitoring software will be purchased and polices developed to monitor and measure improper Internet usage.

Target Completion Date: November 1, 2005.

(d) **Concur**. The IRM Service Line will develop policies and procedures to ensure the segregation of incompatible duties.

Target Completion Date: November 30, 2005.

(e) **Concur**. The ISO had been given a temporary collateral assignment to redesign and implement an improved system for the inspection of controlled substances. At the time of the CAP review, the ISO was in the final stages of this assignment. As a result of the CAP, we have accelerated the completion phase, and the Controlled Substances Inspection responsibility is in the process of being transferred from the ISO to another individual. As of September 6, 2005, a position description had been written, recruitment was completed, and an individual was selected. That individual is currently being trained and will shortly be fully competent to assume responsibility for the CSI program. Thus, by October 1, 2005, the ISO will be able to return to his full-time information security responsibilities.

Target Completion Date: October 1, 2005.

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by performing pre-award reviews.	$406,015
2	Better use of funds by reducing excess medical and prosthetic supply inventories.	537,358
	Total	$943,373

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Janet Mah (310) 268-4335
Acknowledgments	Julio Arias Daisy Arugay Carin Childress Gary Clark Frank Giancola Andrew Hamilton Tamara Jacobson Brian Linton Pauline Murano Michelle Porter Vishala Sridhar Julie Watrous Jeff Wieters Wilma Wong

Appendix E

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