Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Illiana Health Care System Danville, Illinois

Report No. 05-03220-108 **March 22, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Page

Executive Summary i

Introduction 1

System Profile 1

Objectives and Scope of the CAP Review 2

Results of Review 4

Organizational Strength 4

Opportunities for Improvement 5

Environment of Care 5

All Employee Survey 6

Quality Management 6

Inventory Management 7

General Post Funds 8

Government Purchase Cards 8

Contract Administration 9

Agent Cashier 10

Information Technology Security 11

Appendixes

A. VISN Director's Comments to Office of Inspector General's Report 14

B. Monetary Benefits in Accordance with IG Act Amendments 18

C. OIG Contact and Staff Acknowledgments 19

D. Report Distribution 20

Executive Summary

Introduction

During the week of November 14–18, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Illiana Health Care System, Danville, IL (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

This CAP review focused on 13 areas. As indicated below, there were no concerns identified in four of the areas. The remaining nine areas resulted in recommendations for improvement.

The system complied with selected standards in the following areas:

- Accounts Receivable
- Controlled Substances
- Employee Travel
- Unliquidated Obligation

Based on our review, the following organizational strength was identified:

- Restraint Usage Was Significantly Reduced in the Extended Care Service (ECS).

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

- Correct environmental and safety deficiencies.
- Formalize action plan for All Employee Survey (AES).
- Complete Utilization Management[1] (UM) Reviews as required.
- Include engineering cost items in Generic Inventory Package (GIP), record stock levels accurately, and reduce stock levels to a 30-day supply.
- Return unused research funds, and deactivate the inactive General Post Fund (GPF) account.

[1] UM is the process of evaluating and determining the coverage and the appropriateness of medical care services across the patient health care continuum to ensure proper use of resources.

- Follow up on outstanding purchase card transactions, and ensure that purchases are not split.

- Document justification for contract renewals, and review invoices before issuing contract payments.

- Establish local procedures to secure cash boxes during unannounced audits, and independently verify the Agent Cashier's bank balance during an unannounced audit.

- Select an alternative information technology (IT) processing site, complete the system contingency plan, and conduct a risk assessment on the cited ventilation problems.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

VISN Director Comments

The VISN Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 13 for the full text of the Director's comments.) We will follow up on planned actions until they are completed.

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

Introduction

System Profile

Organization. Located in Danville, IL, the system provides a broad range of inpatient and outpatient healthcare services. Outpatient care is also provided at four community-based outpatient clinics (CBOCs) located in Decatur, Peoria, and Springfield, IL; and West Lafayette, IN. The Effingham, IL, CBOC, which is affiliated with Marion, IL, VA Medical Center also serves some veterans from this system's catchment area. This system is part of VISN 11 and serves a veteran population of about 147,000 in a primary service area that includes approximately 34 counties in central and west central Illinois and west central Indiana.

Programs. The system provides primary and secondary healthcare services including medical, surgical, and psychiatry. Nursing home care is provided in a skilled care environment with special focus on rehabilitation, Alzheimer's care, dementia, palliative, gero-psychiatric, and extended care. Ambulatory care services offered include primary care, ambulatory surgery, mental health, substance abuse, and specialty care. The system has 129 operating hospital beds and 217 operating nursing home beds. Administrative support is provided to two readjustment counseling centers in Peoria and Springfield and to two national cemeteries in Danville and Springfield. The system also has sharing agreements with National Emergency Services Government Services, United Radiology, Provena Health Care, Precision Diagnostic, and Southern Illinois University.

Affiliations and Research. VAIHCS is affiliated with the University of Illinois College of Medicine and supports 21 medical resident positions in 2 training programs; 1 in Danville and 1 in Peoria. In Fiscal Year (FY) 2005, the VAIHCS research program had two projects completed and closed (diabetes and Ethics Self-Assessment Tool Kit Project) and three ongoing research projects (violence, biomarkers for oral cancer, and nurse case manager model for chronic heart failure). The total amount of funds for research totaled $1,444.

Resources. In FY 2004, the system's medical care expenditures totaled $126.3 million. The FY 2005 medical care budget was $132.8 million, which was approximately 4.8 percent more than FY 2004 expenditures. FY 2005 staffing was approximately 1,180 full-time employee equivalents (FTE), including 49 physician and 405 nursing FTE.

Workload. In FY 2005, the system treated 30,638 unique patients, a 2 percent increase over FY 2004. The inpatient workload totaled 3,102 discharges, and the average daily census was 71 for the hospital and 203 for the nursing home. The outpatient workload was 241,123 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, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information medical facilities use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on recommendations included in our previous CAP Review report of the system (*Combined Assessment Program Review of the VA Illiana Health Care System*, Report No. 03-00987-172, dated August 26, 2003). We made three follow-up recommendations related to environment of care, quality management, and inventory management.

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

Accounts Receivable	General Post Funds
Agent Cashier	Government Purchase Card Program
All Employee Survey	Information Technology Security
Contract Award and Administration	Inventory Management
Controlled Substances	Quality Management
Employee Travel	Unliquidated Obligation
Environment of Care	

The review covered system operations for FY 2004, FY 2005, and FY 2006 through October 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we interviewed 30 patients to determine their satisfaction with the timeliness of service and the quality of care. The interview results were provided to management.

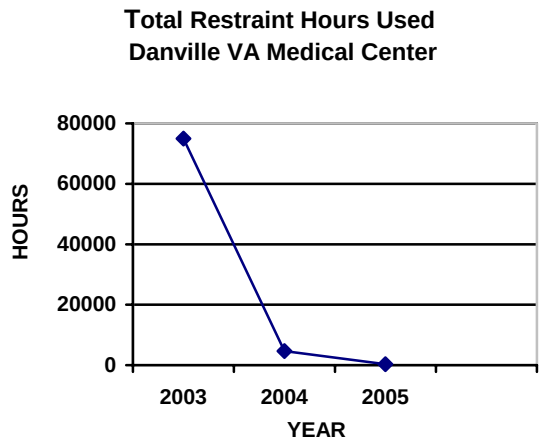
During the review, we presented three fraud and integrity awareness briefings for system employees. These briefings, attended by 62 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

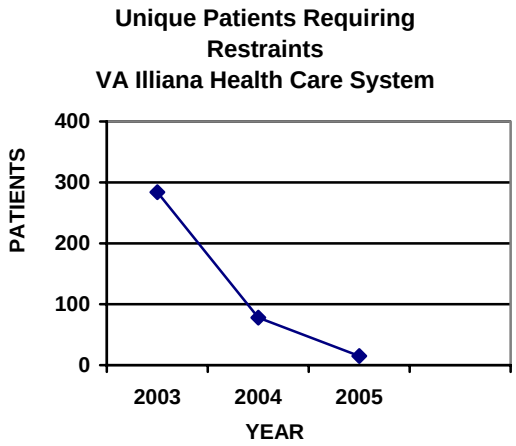
Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strength section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-11). For these activities, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Organizational Strength

Restraint Usage Was Significantly Reduced in the Extended Care Service. In FY 2003, Nursing Service managers focused on efforts to reduce restraint usage by 10 percent in the Extended Care Service. This goal was accomplished with astounding results. Corresponding numbers of unique patients requiring restraints for the same years has also decreased by 96 percent.





To accomplish these reductions in numbers of patients restrained and the hours patients remained in restraints, managers took the following actions:

- Nursing staff received specialized training in assessment and restraint alternatives.
- Staff conducted monthly reviews of restraint usage.
- Managers provided recognition to staff for their efforts to reduce restraint usage.
- Bed and chair alarms that activate with patient movement were utilized.
- Patients received “busy aprons” to stimulate and occupy their attention.
- Staff was assigned to the dayroom to monitor patients and provide activities.
- Staff began an ambulation program to provide regular exercise for patients.
- Staff took patients off the unit to provide a change of scenery.
- Staff increased the frequency of nursing rounds to assess patient comfort issues.

Opportunities for Improvement

Environment of Care – Identified Deficiencies Needed To Be Corrected

Condition Needing Improvement. We inspected a sample of occupied and made-ready patient rooms; common areas such as dayrooms and alcoves, dining rooms, and patio areas; and private and communal restrooms in five patient care areas. The environment was generally clean and maintained. We also followed up on recommendations to correct environmental deficiencies identified during the previous CAP review. The following issues required further management attention.

- Stained privacy curtains.
- Rusted and dirty air system covers.
- Cracked and broken tiles on commode pedestals in patient restrooms.
- Poor ventilation in some medication rooms resulting in very hot rooms.

Follow-Up from the Previous CAP Review. We observed the following sanitation and maintenance deficiencies in the Nutrition and Food Service main kitchen:

- Rust or mold-like stains on ceiling exhaust vent.
- Heavy debris trapped inside the floor drainage cover in the food preparation room.
- Shelves in the preparation storage area with less than the required 6-inch clearance off the floor.
- Ceiling penetration above the dishwasher.
- Cracked and missing wall tiles.

We inspected five emergency eyewash/shower stations in clinical areas and found that three did not consistently have required weekly inspections. Occupational Health and Safety Administration requires that these be tested weekly to ensure proper functioning.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director takes action to correct the environmental and safety deficiencies identified.

The VISN Director agreed with the findings and recommendations. The identified environmental and safety deficiencies have been noted and corrective actions have begun. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

All Employee Survey – Action Plans Needed To Be Formalized

Condition Needing Improvement. The Executive Career Field Performance Plan for FY 2005 directs that the VISN will ensure that results from the 2004 AES are widely disseminated throughout the network by, at a minimum, conducting a town hall meeting open to all employees at each facility during the rating period. VISNs were to have analysis of the 2004 AES results, with formulation of action plans to address target areas for improvement, completed by September 30, 2004. Plans must demonstrate milestones that include timeliness and measures that assess achievement. The system met the requirement of disseminating the AES information to staff through town hall meetings and through postings in their newsletter. Managers were concerned that the 2004 AES yielded only a 28 percent employee return. As a result, efforts were made to publicize a second survey, which was conducted in March 2005. This second survey yielded a 48 percent return. Managers identified four target areas for improvement from the second survey; however, a formalized action plan was not developed.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director develops a formalized action plan for the identified target areas for improvement based on results of the AES.

The VISN Director agreed with the findings and recommendations. A formalized action plan will be finalized based on the four identified target areas from the March 2005 AES. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management – Utilization Management Data Analysis Needed To Be Accomplished

Condition Needing Improvement. The QM program was generally effective, but 1 of the 14 program areas needed improvement. Although managers had strengthened processes to critically analyze performance improvement data since the previous CAP review in 2003, we found that due to staffing shortages the QM staff had not performed continued stay appropriateness reviews for the 18 months prior to our CAP review. Continued stay appropriateness is a component of UM and is required by Joint Commission on Accreditation of Healthcare Organizations and VHA to increase the efficiency and appropriateness with which services are provided and resources are utilized. Patient care can be improved by sharing data on events that might require extended lengths of stay.

In July 2005, managers approved a new UM plan that addresses this deficiency. They have also created a new UM section to conduct admission, length of stay, fee-basis transfers, and other utilization reviews.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director requires that thorough UM reviews, including continued-stay appropriateness, are completed as required.

The VISN Director agreed with the findings and recommendations. All required UM reviews including continued-stay appropriateness are completed in acute medical/surgical and behavior health inpatients meeting the requirements outlined in VHA Directive 2005-009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Inventory Management – Internal Controls Needed To Improve Inventory Accuracy and Reduce Stock Levels

Condition Needing Improvement. VA policy requires monitoring of stock levels through annual inventories and implementation of the GIP and the Prosthetics Inventory Package (PIP). Policy further requires that inventory levels be limited to a 30-day supply. Materiels Management Section (MMS) staff had performed annual inventories timely and fully implemented GIP and Prosthetics Service staff had implemented PIP. However, information in GIP was not accurate, and stock levels exceeded the maximum 30-day supply for some items.

Values of Engineering Stock Items Were Not Recorded in GIP. The October 26, 2005, GIP report showed that there were 1,110 items of engineering stock on hand. However, MMS staff had not recorded the costs in GIP for 671 (60 percent) of the 1,110 items. The value of the 439 engineering items that MMS did record costs for was $49,644. According to the Chief, MMS, most of the engineering items with no costs recorded in GIP had been placed into inventory before GIP was implemented in August 2004.

Accuracy of GIP. To determine if GIP records were otherwise accurate, we compared GIP inventory records for 45 stock items with amounts actually on hand. GIP records did not accurately reflect the stock on hand for 15 (33 percent) of the 45 items. Of the 15 incorrectly reported items, 9 were over reported (more stock reported in GIP than on hand) in GIP and 6 were under reported (less stock reported in GIP than on hand). Seven of the 15 items were engineering stock that had no costs entered in GIP. The net effect of the eight remaining incorrect entries was an over reporting of $967.

Stock in Excess of 30 Days Supply. According to the October 26, 2005, GIP report and the October 27, 2005, PIP report, the system had a total of 3,131 items of stock on hand with a value of $511,459. Of these 3,131 items, 2,820 were reported in GIP and 311 were reported in PIP. Of the 3,131 items, 2,563 (82 percent) exceeded the 30-day supply level. These 2,563 items had a value of at least $284,676. The cost of engineering stock could not be accurately determined because the costs of all engineering stock had not been entered into GIP. System staff stated they were aware they had excessive amounts of stock on hand and that efforts were ongoing to reduce stock levels.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director takes action to: (a) ensure that the cost of engineering items are included in GIP, (b) ensure that stock levels recorded in GIP are accurate, and (c) reduce stock levels to a 30-day supply.

The VISN Director agreed with the findings and recommendations. A comprehensive review of the GIP program will be conducted with emphasis of accurate data entries, inventory management, and compliance with 30-day supply stock levels. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

General Post Funds – One Account Needed To Be Closed

Condition Needing Improvement. Fiscal Service staff managed 30 GPF accounts with a combined value of $402,486. A review of 20 GPF donations and 20 GPF expenditures showed that all 40 transactions were posted to accounts accurately and timely.

However, Fiscal Service staff did not deactivate one GPF account as required. VA policy requires the deactivation of GPF accounts that have had no activity over a 12-month period. As of November 2005, one account with a balance of $11,504 showed no activity for 24 months but was still active. The account was for medical research funded through VA Medical Center (VAMC) Bedford, MA, but no research had been performed by system staff. Accounting Section staff in Fiscal Service stated that they had attempted to return the funds to VAMC Bedford, but had not been successful because the $11,504 was prior year funding.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director takes actions to de-obligate the funds and deactivate the inactive GPF account.

The VISN Director agreed with the findings and recommendations. An acceptable target date was given for completion. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Cards – Follow-Up Was Needed on Outstanding Purchases and One Transaction Was Split

Condition Needing Improvement. VA policy requires that cardholders reconcile 75 percent of purchases within 10 calendar days and that officials approve purchases within 14 working days. Policy also prohibits the splitting of larger purchases into smaller ones to avoid limitations on individual purchase cards. As of November 14, 2005, the system had 49 cardholders and 21 approving officials who were responsible for 99 purchase cards. These included 8 cardholders, 5 approving officials, and 32 purchase cards distributed among the VAMC Marion, IN; Prosthetics Service at the VAMC

Indianapolis, IN; the Peoria, IL, CBOC; the Springfield, IL, Veterans Center; and the Danville and Camp Butler, Illinois, National Cemeteries. During FY 2005, cardholders executed 16,880 purchase card transactions totaling $7.2 million. We found that cardholders reconciled 93 percent of their purchases within 10 calendar days and approving officials approved 92 percent of transactions within 14 working days. However, cardholders did not follow up outstanding transactions, and one purchase for $2,812 was split to avoid a purchase card limit of $2,500.

Cardholders Did Not Close Outstanding Accounts Timely. As of November 17, 2005, the system had 214 outstanding purchase card transactions totaling $134,712. The average age of these transactions was 180 days. One cardholder at VAMC Indianapolis was responsible for 95 of the 214 outstanding transactions. These 95 transactions totaled $37,152, and their average age was 293 days. These accounts remained open for extended periods because cardholders were not following up to resolve partial shipments, returns for credit, or other problems with vendors. As a result, the cardholders could not close outstanding transactions.

Split Purchase. One purchase of $2,812 was split into a series of three purchases to avoid the purchase card limitation of $2,500. Because the purchase exceeded the purchase card limitation, the cardholder or the approving official should have contacted the Purchase Card Coordinator to arrange for a cardholder with a larger purchase authority to complete the transaction and to avoid splitting the purchase.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the System Director and VISN Chief Logistics Officer take action to (a) require that cardholders follow up and close outstanding purchase card purchase transactions and (b) ensure that purchases are not split to avoid purchase card limits.

The VISN Director agreed with the findings and recommendations. Purchase card transactions will be addressed to ensure full compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Contract Administration – Justification for Contract Renewals Needed To Be Documented and Contract Payments Were Not Always Correct

Condition Needing Improvement We reviewed 10 contracts consisting of 4 leases of varying lengths totaling $4.3 million, 2 medical contracts totaling $3.6 million, and 4 service contracts totaling $2.6 million annually. Contracting staff did not always justify contract renewals as required by Federal Acquisition Regulations (FAR) and VISN 11 policy or ensure that contract payments were correct.

Contract Renewals Were Not Adequately Justified. Contracting officers did not document justification of decisions to exercise renewal options for two leases totaling $3 million. The FAR requires all contracting decisions to be documented, and VISN 11

policy requires that the contracting officers include a statement of satisfactory contractor performance before exercising a contract renewal option. The contract files for renewal of the two leases did not include this statement. According to the Chief Contracting Officer, the lack of documented justification resulted from contracting officer oversights.

Payments to a Vendor Were Incorrect. Payments to a contractor under the terms of a contract totaling $672,000 for laundry services were incorrect. This occurred because invoices were not adequately reviewed by the Contracting Officer's Technical Representative before payments were made. A review of six invoices for services provided to the medical center from July 1, 2005, to September 30, 2005, showed that the contractor was overpaid on one occasion and underpaid on another. As a result, the contractor received a total of $3,268 instead of $3,435 as specified by the contract—an under payment of $167.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the System Director requires that contracting staff (a) adequately document justification for contract renewals and (b) review invoices before issuing contract payments.

The VISN Director agreed with the findings and recommendations. Documentation justification for contract renewals and invoice review prior to payments will be addressed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Agent Cashier – Unannounced Audit Procedures Needed To Be Improved

Condition Needing Improvement. Physical security of the Agent Cashier's area was adequate, and the size of the Agent Cashier cash advance was appropriate for the needs of the system based on the turn-over rate. The System Director had custody of the Agent Cashier's safe combination and duplicate keys for the Agent Cashier's cash boxes, and the combination and keys were adequately secured. However, there were two conditions that needed to be improved.

System Auditors Could Not Access Cash Boxes**.** VA policy requires that auditors account for the Agent Cashier and Alternate Agent Cashiers' advances, vouchers, and receipts during unannounced audits. According to the unannounced audit report for April 2005, auditors were unable to verify an alternate cashier's $2,000 cash advance for 4 days because the alternate cashier was on leave. Since the alternate cashier was not available, the auditors should have secured the cash box or used the duplicate key secured in the Director's office to open the box and count the cash.

Checkbook Balances Were Not Verified**.** During an OIG-requested unannounced audit during the CAP review, the auditors accepted the balance shown in the checkbook

register as the Agent Cashier's bank balance without verifying it. We performed a subsequent independent verification of the account balance by comparing the online bank statement with the checkbook register and found the amount to be correct. However, auditors should have verified the balance during the unannounced audit.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the System Director takes action to (a) establish local procedures to account for or secure cash boxes for those instances when the alternate cashiers are not present during unannounced audits and (b) ensure that the Agent Cashier bank balance is independently verified as part of the unannounced audit.

The VISN Director agreed with the findings and recommendations. Adjustments to the unannounced audit process including cash box modifications and independent verification of agent cashiers balances will be done. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Security and Environmental Controls Needed Improvement

Condition Needing Improvement. IT staff had implemented effective controls to ensure virus protection, cancellation of inactive computer accounts, and password protection. In addition, system staff received required security awareness training, and IT managers had requested appropriate background investigations for staff assigned to sensitive positions. However, there were three areas where management could improve IT security and environmental controls.

An Alternative Processing Site Had Not Been Identified. System IT staff informed us that VISN 11 IT staff were developing a plan for alternative processing sites for all facilities in the VISN. They also said that all responsibility for its implementation resided at the VISN level. Because an alternate processing site had not been identified, system and VISN 11 IT staff could not provide assurances that the system could recover data and continue operations in the event of an emergency that disabled the system's IT plant and/or equipment.

The System Contingency Plan Had Not Been Developed. VA policy requires that IT staff develop contingency plans in accordance with National Institute of Security Technology (NIST) standards for all agency information systems. To facilitate development of the plans, the VHA Office of Cyber Information Security distributed a template to all VHA facilities in March 2005. At the time of our review, the Information Security Officer (ISO) had not completed the system's contingency plan as required. The ISO stated that a plan was under development and anticipated completion by March 2006.

Some IT Space Was Not Environmentally Controlled. Two IT communication and electrical closets were very warm. One closet had no ventilation. Although the second had a vent on the lower part of its door, it was located across a narrow hallway from a radiator. VHA policy and NIST requirements state that when a potentially unacceptable environmental or security condition exists, staff should perform a risk assessment to determine the potential effects of the condition and whether the risks associated with the condition are acceptable. The ISO and IT staff should perform an assessment to determine whether the equipment located in these closets is likely to fail if temperatures are not reduced. Based on the results of this assessment, the System Director should either resolve the ventilation problems or document acceptance of the risks of not correcting them.

Recommended Improvement Action 9. We recommended that the VISN and System Directors ensure that: (a) VISN IT staff assist system IT staff in selecting an alternative processing site, (b) the system ISO completes the system's contingency plan, and (c) system management and staff perform a risk assessment and either correct cited ventilation problems or document acceptance of the risks associated with them.

The VISN Director agreed with the findings and recommendations. VISN 11 Alternative Site Processing Draft Memo is in review and approval process. The alternative processing site for VA Illiana Health Care System has been identified, and implementation is to occur after policy approval. Completion of the contingency plan will be accomplished. A Risk Assessment will be completed with recommendations forwarded to the Director for a decision. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 7, 2006

From: Network Director, VISN 11 (10N11)

Subject: **CAP Review of VA Illiana HCS, 2005-032209-HI-0314**

To: Director, Chicago Regional Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

Per your request, attached is the response to the draft report from VA Illiana HCS.

If you have any questions, please contact Frank M. Miles, VISN 11 QMO, at (734) 222-4314.

Linda W. Belton

Attachment

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

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the System Director takes action to correct the environmental and safety deficiencies identified.

Concur **Target Completion Date:** 5/1/06

The identified environmental and safety deficiencies have been noted and corrective actions have begun.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the System Director develops a formalized action plan for the identified target areas for improvement based on results of the AES.

Concur **Target Completion Date:** 2/28/06

A formalized action plan will be finalized based on the four identified target areas from the March 2005 All Employee Survey (AES).

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the System Director requires that thorough UM reviews, including continued-stay appropriateness, are completed as required.

Concur **Target Completion Date:** 2/28/06

All required UM reviews including continued-stay appropriateness are completed in acute medical/surgical and behavior health inpatients meeting the requirements outlined in VHA Directive 2005-009.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the System Director takes action to:

(a) ensure that the cost of engineering items is included in GIP,

Concur **Target Completion Date:** 6/30/06

(b) ensure that stock levels recorded in GIP are accurate, and

Concur **Target Completion Date:** 6/30/06

(c) reduce stock levels to a 30-day supply.

Concur **Target Completion Date:** 6/30/06

(a), (b), and (c) -- A comprehensive review of the GIP program will be conducted with emphasis of accurate data entries, inventory management, and compliance with 30-day supply stock levels.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the System Director takes actions to de-obligate the funds and deactivate the inactive GPF account.

Concur **Target Completion Date:** 2/28/06

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the System Director and VISN Chief Logistics Officer take action to:

(a) require that cardholders follow up and close outstanding purchase card purchase transactions and

Concur **Target Completion Date:** 2/28/06

(b) ensure that purchases are not split to avoid purchase card limits.

Concur **Target Completion Date:** 2/28/06

(a) and (b) -- Purchase card transactions will be addressed to ensure full compliance.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the System Director requires that contracting staff:

(a) adequately document justification for contract renewals and

Concur **Target Completion Date:** 4/30/06

(b) review invoices before issuing contract payments.

Concur **Target Completion Date:** 4/30/06

(a) and (b) -- Documentation justification for contract renewals and invoice review prior to payments will be addressed.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the System Director takes action to:

(a) establish local procedures to account for or secure cash boxes for those instances when the alternate cashiers are not present during unannounced audits and

Concur **Target Completion Date:** 3/31/06

(b) ensure that the Agent Cashier bank balance is independently verified as part of the unannounced audit.

Concur **Target Completion Date:** 3/31/06

(a) and (b) -- Adjustments to the unannounced audit process including cash box modifications and independent verification of agent cashiers balances will be done.

Recommended Improvement Action 9. We recommend that the VISN and System Directors ensure that:

(a) VISN IT staff assist system IT staff in selecting an alternative processing site,

Concur **Target Completion Date:** VISN policy in draft (as of 2/1/06); target date June 6, 2006

VISN 11 Alternative Site Processing Draft Memo is in review and approval process. The alternative processing site for VA Illiana Health Care System has been identified (Primary = Indianapolis VAMC; Secondary = Ann Arbor VAMC). Implementation is to occur after policy approval.

(b) the system ISO completes the system's contingency plan, and

Concur **Target Completion Date:** 3/8/06

Currently the contingency plan is 98% completed. Completion of the contingency plan will be accomplished.

(c) system management and staff perform a risk assessment and either correct cited ventilation problems or document acceptance of the risks associated with them.

Concur **Target Completion Date:** 4/14/06

A Risk Assessment will be completed with recommendations forwarded to the Director for a decision. The Risk Assessment will be conducted by a facility team including the Chief IRM, Network Manager, ISO and Alternate ISO.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
4	Reducing excess stock would make funds available for other uses.	$284,676
	Total	$284,676

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	John Brooks Paula Chapman Larry Chinn Patricia Conliss Kenneth Dennis Theresa Golson Wachita Haywood Raymond Jurkiewicz Dana Martin Cynnde Nielsen Leslie Rogers William Wells

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 11 (10N11)
Director, VA Illiana Health Care System (550/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Government Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
The Honorable Richard Durbin, U. S. Senate
The Honorable Barack Obama, U. S. Senate
The Honorable Evan Bayh, U. S. Senate
The Honorable Richard Lugar, U. S. Senate
The Honorable Lane Evans, U. S. House of Representatives
The Honorable Ray LaHood, U. S. House of Representatives
The Honorable John Shimkus, U. S. House of Representatives
The Honorable Tim Johnson, U. S. House of Representatives
The Honorable Steve Buyer, U. S. House of Representatives
The Honorable John Hostettler, U. S. House of Representatives
The Honorable Peter Visclosky, U. S. House of Representatives

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