



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, Pennsylvania

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 November 14–18, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James E. Van Zandt VA Medical Center, which is part of Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected medical center 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 133 medical center employees.

Results of Review

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

- Accounts Payable
- Government Purchase Card Program
- Controlled Substances Accountability
- Laboratory and Radiology Services
- Equipment Accountability
- Service Contracts

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

- Improve adverse outcome discussions and action plan evaluations.
- Correct environment of care deficiencies.
- Reduce excess medical supply inventories and improve inventory controls.
- Strengthen accounts receivable collection and write-off procedures.
- Strengthen information technology security controls.

This report was prepared under the direction of Ms. Janet Mah, Director, and Mr. Shoichi Nakamura, CAP Review Team Leader, Los Angeles Audit Operations Division.

VISN 4 and Medical Center Directors Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–18, for the full text of the Directors’ comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Medical Center Profile

Organization. The medical center provides inpatient and outpatient health care services in Altoona, PA, and provides outpatient care at community-based outpatient clinics located in Dubois, Johnstown, and State College, PA. The medical center, which is part of the VA Stars and Stripes Health Care Network, serves a veteran population of about 73,000 in a primary service area that includes 9 counties in central Pennsylvania.

Programs. The medical center's 68-bed inpatient facility offers general acute and extended care and special extended care programs including respite care and hospice. The medical center provides outpatient services through the emergency room and primary and specialty care clinics. For specialty services that are not available at the medical center, patients are referred to the VA Pittsburgh Healthcare System, local contractors, or fee-basis providers. The medical center also has sharing agreements with the Pennsylvania Army National Guard and the State Veterans Home in Hollidaysburg, PA.

Affiliations and Research. The medical center is affiliated with 10 universities, colleges, and technical schools, including Pennsylvania State University, the University of Pittsburgh, and Duquesne University. The medical center's affiliated training programs include nursing, physician assistant, pharmacy technician, and medical administrative assistant. Currently, the medical center does not have a research program.

Resources. The medical center's fiscal year (FY) 2005 budget was \$63.3 million, a 3 percent decrease over the FY 2004 budget. FY 2005 staffing was 469 full-time equivalent employees (FTE), including 24.7 physician FTE and 78.6 nursing FTE.

Workload. In FY 2005, the medical center treated 24,101 unique patients, a 1.7 percent increase over FY 2004. Medical center officials attribute the increase to a continuous influx of new veterans seeking medical care. The FY 2005 inpatient care workload totaled 1,118 discharges with an average daily census of 14.2 patients and the outpatient workload was 182,864 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 11 activities:

Accounts Payable	Information Technology Security
Accounts Receivable	Laboratory and Radiology Services
Controlled Substances Accountability	Quality Management
Environment of Care	Service Contracts
Equipment Accountability	Supply Inventory Management
Government Purchase Card Program	

The review covered facility operations for FYs 2004 to 2006 through November 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–10). In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement Section, we did not identify any reportable deficiencies.

During the review, we also presented 3 fraud and integrity awareness briefings to 133 employees. These briefings 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.

Follow-Up to Previous CAP Review Recommendations

As part of this review, we followed up on recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the James E. Van Zandt VA Medical Center*, Report No. 03-03208-76, February 2, 2004). In 2004, we found that the Medical Center Director needed to develop and implement a comprehensive QM program that included strengthened review processes, improve fee-basis program administration, consider contracting some fee-basis services, and properly monitor and administer service contracts. Our November 2005 CAP review found that medical center management had implemented adequate corrective actions for the conditions identified

during the previous CAP review except for the QM program, which still needed improvement. (See Opportunities for Improvement section, page 4.)

Results of Review

Opportunities for Improvement

Quality Management – Adverse Outcome Discussions and Action Plan Evaluations Needed To Be Improved

Conditions Needing Improvement. The QM program was generally effective but certain QM reviews and processes needed to be strengthened. Of the 12 program areas reviewed, 10 areas had appropriate review structures and 2 needed improvement.

Adverse Outcome Discussions. During FYs 2004–2005, responsible clinical staff documented adverse outcome discussions held with three patients. However, for one of the three patients the medical record lacked documentation to show that he had been informed of his right to file claims. Veterans Health Administration (VHA) and medical center policies require clinical staff to discuss adverse outcomes with patients and their families, to inform them of their rights to file tort or benefit claims, and to document these notifications in the patients' medical records.

Action Plans. Program managers did not consistently identify evaluation criteria and evaluate and monitor action plans to determine whether the plans effectively corrected problems as required by the Joint Commission on Accreditation of Healthcare Organizations. For example, a medical center committee determined that a radiologist did not comply with the requirement to notify the ordering provider when an abnormal chest x-ray was identified. The medical center implemented an action plan and closed the item without identifying any evaluation criteria or conducting any further monitoring to ensure that the action plan was effective.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director require that (a) clinical staff advise all patients and their families who experience adverse outcomes of their rights to file claims and document the notifications in the patients' medical records and (b) program managers evaluate and monitor QM action plans to ensure their effectiveness.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that injuries are being referred to the Chief of Staff who is responsible for directing the institutional disclosure process and that clinical staff are using a template to document adverse events, offer assistance, address questions, and notify patients of their rights to file administrative tort claims. In addition, chairpersons on the Leadership Staff Council and service chiefs have been notified that they are required to follow through on action plans until the plans are completed and to monitor the effectiveness of the action plans. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care – Infection Control of Patient Care Areas and Equipment Needed To Be Strengthened

Conditions Needing Improvement. VHA regulations require the medical center to provide a safe environment for patients, employees, and visitors and to employ infection control practices that reduce the risk of hospital acquired infections. Although the medical center's environment of care was generally clean, six areas needed improvement.

Bulk Oxygen Alarm System. The medical center had not implemented safeguards for its oxygen utility systems as required by VHA policy. In April 2004, a VHA Patient Safety Alert directed VA facilities to establish at least two independent surveillance stations and alarm systems to monitor all facility oxygen utility systems 24 hours a day, 7 days a week. If a VA facility could not meet this standard, they were required to publish a comprehensive Interim Life Safety Measure to fully address and compensate for the deficiencies in their surveillance program. These requirements were later incorporated in VHA policy. As of November 2005, the medical center's oxygen inventory system had only one operational alarm system and it was not continuously monitored. A second system had been installed, but it was not yet operational.

Unfinished Work Orders. Maintenance work orders were not completed promptly. As of November 2005, painting work orders were backlogged from 1998, repair work orders for equipment and machinery had been pending since February 2003, and electrical work orders from January 2005 had not been completed. However, an inspection of six randomly selected medical equipment items showed that five of the six items had received timely, preventive maintenance.

Physical Plant Repairs. Physical plant repairs needed to be addressed to ensure patient, visitor, and employee safety. The ceiling of the old entrance to the main medical center building was water-damaged and appeared ready to collapse, ceiling tiles in the Intensive Care Unit were damaged, and shower room floor tiles in the sixth floor Long Term Care Unit were broken.

Non-Operational Alarm System. The alarm system, which alerts staff when a door to the outside is opened, did not work in the Nursing Home Care Unit. This alarm system is critical to ensuring the safety of veterans with varying levels of mental capacity who might try to leave the Nursing Home Care Unit. Although this problem was identified in an October 2004 medical center Safety Committee report, the medical center did not award a contract to correct this problem until September 2005. At the time our review, a contractor was installing a replacement alarm system.

Patient Safety and Sanitation Inspection Follow-Up. The Safety Committee did not document the actions taken to correct deficiencies identified during routine safety and sanitation rounds. Although service line managers were notified in writing of

deficiencies identified during the rounds, the Safety Committee's meeting minutes did not show what corrective actions had been taken.

Respiratory Protection Program Training. Medical center staff respiratory protection training was not properly tracked. Respiratory protection training helps to ensure medical center staff properly treat patients with highly infectious diseases and minimizes the risk of patients contracting such diseases. Medical center policy requires initial and annual refresher Respiratory Protection Program training received by employees to be tracked in the computerized Training and Education Management Program (TEMPO). Despite the availability of TEMPO, employee respiratory training was not tracked.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director require that:

- a. Medical center staff monitor the medical center's oxygen utility systems as required by VHA regulations.
- b. Engineering Service staff promptly complete work orders and repair physical plant deficiencies.
- c. Contractors complete the replacement of the alarm system as soon as possible.
- d. Safety Committee staff document corrective actions taken to address identified environment of care deficiencies.
- e. Medical center staff track initial and annual employee respiratory protection training in TEMPO.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a newly installed second oxygen utility alarm system is operating and is monitoring all facility oxygen utility systems 24 hours a day, 7 days a week. Needed physical plant repairs have been initiated or have already been completed, and several low priority and completed work orders have been closed out. Also, a new system to prevent Nursing Home Care Unit patients from wandering has been installed and activated. The facility Safety Manager will conduct quarterly reviews of all safety and sanitation surveys and will report findings to the Safety Committee. Finally, TEMPO has been updated to reflect the initial Respiratory Protection Program training provided all medical center staff and it will be used to track subsequent training. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Condition Needing Improvement. Inventory Supply Management (ISM) needed to manage stock levels more effectively and make better use of automated inventory controls. VHA's policy establishes a 30-day supply goal and requires medical facilities to use VA's Generic Inventory Package (GIP) to manage inventories. ISM should use GIP to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and conduct physical inventories.

As of November 22, 2005, the medical center's medical supply inventory, excluding laboratory supplies, included 918 items with a total inventory value of \$50,717. For a sample of 20 medical supply items valued at \$6,705, we compared the recorded GIP quantities with our physical counts and found GIP records were accurate. Our review of GIP reported inventory levels for the 918 items disclosed 757 medical supply items had inventory levels ranging from 31 to 9,999 days of supply. The excess inventory totaled \$33,810 or 67 percent of the total medical supply inventory value. According to ISM managers, the medical center had excess inventory because of vendor minimum order requirements and ISM staff not adjusting normal stock levels in GIP to 30-day levels. ISM staff also stated that the excess inventory developed because they were required to purchase large quantities of supply items through bulk purchase agreements or the General Services Administration and to stock supply items for emergency use.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director require that ISM staff monitor item usage rates and reduce excess medical supply inventory.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that ISM staff use GIP to monitor item usage rates on a recurring basis, and that excess medical supply inventory has been reduced. The improvement plans are acceptable, and we will follow up on the completion of the planned action.

Accounts Receivable – Accounts Receivable Write-Off and Segregation of Duty Requirements Needed To Be Followed

Conditions Needing Improvement. Revenue Section staff improperly canceled accounts receivable and the Resources Department Manager did not properly segregate agent cashier and VA Financial Management System (FMS) accounting duties. VA policy requires accounts receivable to be written off in FMS when medical center managers determine that further collection actions are no longer cost effective. In addition, individual employees should not be allowed to both establish and maintain accounts receivable in FMS and to accept and record payments, because this weakens internal controls meant to prevent the diversion of funds. As of November 30, 2005, the medical center had 39,920 receivables totaling \$2.6 million. Our review found two areas that needed improvement.

Cancellation of Receivables. Revenue Section staff improperly canceled accounts receivable instead of writing them off. VA policy states that accounts receivable should only be canceled in FMS to correct errors such as duplicate entries. However, during FYs 2004–2005, Revenue Section staff canceled 36,304 accounts receivable that they deemed uncollectible. The Revenue Coordinator stated that these accounts receivable were improperly canceled because they were not aware of VA's policy requiring the write-off of uncollectible accounts receivable. As of November 2005, the Revenue Coordinator could not provide the total value of the canceled accounts receivable,

because this information could not be extracted from FMS without a specially written computer program.

Segregation of Duties. The Resources Department Manager had not properly segregated agent cashier duties and accounting functions related to the management of accounts receivable. An agent cashier, who was assigned the duty of collecting cash and check payments for accounts receivable, also had the authority to cancel accounts receivable in FMS. As a result, the agent cashier could have received payments, diverted the funds, and then canceled the related accounts receivable in FMS with minimal risk of detection. The agent cashier had been assigned these duties due to a shortage of staff in the Resources Department. The Resources Department Manager did not realize that this lack of segregation of duties increased the risk of funds being diverted and did not follow VA internal control policies. As a result of our review, medical center management terminated the agent cashier's authority to cancel accounts receivable in FMS and planned to conduct audits of the canceled accounts receivable and supporting financial documentation to ensure payments had not been diverted. If any audits indicated possible funds diversion, the medical center's VA Police planned to notify the OIG as required.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director require that: (a) Revenue Section staff properly write-off uncollectible accounts receivable, (b) the Resources Department Manager segregates agent cashier duties and accounting functions related to the management of accounts receivable in FMS, (c) the Resources Department conduct audits of canceled receivables and supporting financial documentation, and (d) VA Police notify the OIG if any audits indicate that funds were diverted.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the responsible staff were writing off uncollectible accounts receivable and that the agent cashier duties and accounting functions have been segregated. In addition, the Resources Department is conducting audits of the canceled accounts receivable and to date, has not found any problems. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. The Information Security Officer (ISO) and Information Resources Management (IRM) needed to strengthen automated information systems (AIS) controls. VA and VHA policies require each facility to establish, maintain, and enforce a comprehensive information security program to ensure adequate levels of protection are in place for all AIS. These controls protect AIS assets and sensitive information from unauthorized access, disclosure, modification, destruction, or

misuse, as well as the continuance of business operations following disruption or disaster. Our review found five areas that needed improvement.

Contingency Planning. The medical center's AIS contingency plan was incomplete because it lacked backup tape retrieval procedures, damage assessment procedures, hardware and software inventories, lines of succession, and resource recovery priorities. This occurred because the medical center used an outdated format and had not updated the plan using VHA's new contingency plan template. As of November 2005, the ISO was working on a new contingency plan to address the missing elements of the current plan.

Computer Security Controls. IRM staff had implemented automatic interactive session time-out settings to prevent unauthorized access to unattended computers. However, our tests determined that the settings did not work and that medical center computers remained logged-on even after they were idle for over 30 minutes. The ISO and IRM staff could not explain why the automatic interactive session time-out settings did not work or why the problem had not been detected previously.

System Access. The ISO did not ensure that local area network (LAN) and Veterans Health Information System and Technology Architecture (VistA) access privileges were terminated when users no longer worked for the medical center. VA policy requires LAN and VistA access to be promptly terminated when users leave facilities or no longer need access. As of October 7, 2005, 779 individuals had LAN access. Of these individuals, 516 were current medical center employees. The ISO was not able to provide the users' status for the remaining 263 individuals (34 percent) with LAN access. The ISO indicated that at least 15 of the users were students who participated in the medical center's affiliated training programs and an unknown number of the users were non-VA physicians who required access. In addition, as of October 28, 2005, 158 (44 percent) of 362 VistA users had access privileges, even though they had not logged-on to the system in over a year. In one case, the user had not logged-on since December 1998. These problems occurred because the ISO did not monitor user access privileges every 90 days to determine if access was still required.

Data Backups. IRM staff did not store computer data backups in a secure location before they were transferred to an off-site storage location. VHA policy requires facilities to backup essential data, to store the backup data in a location physically separate from the AIS, and to implement physical and environmental controls to ensure backup data is properly safeguarded. We found that IRM staff routinely stored backed up data for 16 hours before it was transferred to an off-site location in a warehouse which did not meet VHA automated data physical security requirements. The warehouse did not have required security mesh screening on its windows, and one window was covered with plywood to accommodate an air conditioner. Although the warehouse had an operational motion detector, it was not connected to the medical center's police security station.

Security Responsibilities. Medical center management assigned data backup duties to staff but did not reassess their position risk levels and initiate required background screenings. To meet information and computer security requirements, VA policy requires the ISO to assess each position for the possible risk which would result from an employee's loss, misuse, or unauthorized access to VA information and to initiate background screenings commensurate with the level of risk involved. Medical center management assigned an employee to take the data backups and to transport them to an off-site location where another employee stored the backups in a fireproof safe. However, the ISO had not reassessed the position risk levels of these two employees and had not initiated required background screenings.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director require that:

- a. The ISO includes all required information in the AIS contingency plan.
- b. IRM staff ensure computer automatic interactive session time-out settings are working properly.
- c. The ISO promptly terminates LAN and VistA access for users who leave the medical center or who no longer need access.
- d. The ISO reviews LAN and VistA user access privileges at least every 90 days.
- e. Essential backup data is only stored in secure areas.
- f. The ISO reassesses position risk levels and completes required background screenings for employees assigned new IRM responsibilities.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the ISO and the Acting IRM Chief were updating the AIS contingency plan, and the Acting IRM Chief had activated the interactive session time-out setting for all systems. The ISO had reviewed user access privileges and identified those users who no longer worked at the medical center and terminated their access. In addition, the ISO is monitoring user access privileges and working with Human Resources Service and other offices at the medical center to promptly identify users who no longer require LAN and VistA access. The computer data backups are now stored in a locked, secure area in the Police Office before they are transferred to an off-site storage location. Finally, position descriptions will be updated to reflect data backup responsibilities, and background investigations have been or will be completed for staff assigned data backup responsibilities. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

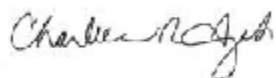
VISN 4 Director Comments

Department of
Veterans Affairs

Memorandum

Date: March 28, 2006
From: Network Director, VA Stars & Stripes Healthcare Network (10N4)
Subj: OIG CAP Review of James E. Van Zandt VAMC Altoona, PA (draft report)
To: Director, Los Angeles Audit Operations Division (52LA)
Thru: Margaret Seleski, Director, VHA Management Review Service (10B5)

I have reviewed the response provided by the James E. Van Zandt VAMC Altoona PA (attached), and I am submitting it to your office as requested. If you have any questions or require additional information, please contact my office at 412-784-3939.



CHARLEEN R. SZABO, FACHE
Network Director

Attachment

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date:

From: Medical Center Director

Subject: James E. Van Zandt VA Medical Center Altoona, PA

To: Director, Los Angeles Audit Operations Division (52LA)

Thru: Network Director, VISN 4 (10N4)

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the James E. Van Zandt VA Medical Center.

2. In brief, I concur with all of the findings and suggested improvement actions. As you will note, the vast majority of the actions have already been completed. The remaining proposed remedies will be completed in the next few months.

3. In closing, I would like to express my thanks to the CAP review team. The team members were professional, comprehensive, and focused. The collective interest and efforts of the CAP review team have helped improve our clinical and business practices at the James E. Van Zandt VA Medical Center.

(original signed by:)

GERALD L. WILLIAMS

Director Comments to Office of Inspector General's Report

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

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) clinical staff advise all patients and their families who experience adverse outcomes of their rights to file claims and document the notifications in the patients' medical records and (b) program managers evaluate and monitor QM action plans to ensure their effectiveness.

Concur **Target Completion Date:** (a)
Completed December 2005 and (b) Completed March 2006

(a) The Quality Management Section refers all level 2 and level 3 injuries to the Chief of Staff for directing the institutional disclosure process. The Chief of Staff and the Risk Manager collaborate, call Regional Counsel, determine disclosure meeting membership, and decide what to disclose, by whom, and how. The clinical staff use the disclosure of adverse event template to document the discussion points of the adverse event, offer assistance, address questions, and advise of 1151 claims process and right to file administrative tort claim. (b) The Director and Chairperson of Leadership Staff Council has informed Council of the requirement of the chairpersons and service chiefs to assure action plans are followed through until completed and further monitoring is done to ensure that the action plans were effective. Additionally, Quality Management Service discussed the OIG CAP findings with chairpersons reporting to the Leadership Staff Council/Performance Improvement on evaluating and monitoring action plans to ensure effectiveness.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires that:

- a. Medical center staff monitor the medical center's oxygen utility systems as required by VHA regulations.
- b. Engineering Service staff promptly complete work orders and repair physical plant deficiencies.
- c. Contractors complete the replacement of the alarm system as soon as possible.
- d. Safety Committee staff document corrective actions taken to address identified environment of care deficiencies.
- e. Medical center staff track initial and annual employee respiratory training in TEMPO.

Concur **Target Completion Date:** (a)
 Completed November 18, 2005, (b) April 28, 2006, (c)
 Completed January 2006, (d) April 30, 2006, and (e)
 Completed January 2006

(a) A second oxygen utility alarm system that will monitor all facility oxygen utility systems 24 hours a day, 7 days a week has been installed in the Police Office, Room 187, and has been in operation as of November 18, 2005. (b) Deficient work orders in the paint shop, machine shop, and electric shop were found to be of a low priority and do not affect the patients or medical center operations. Most work orders were found to be completed but were not closed in a timely manner. These deficient work orders have been closed as of March 16, 2006. An inspection of the plaster ceiling was noted to be safe and not ready to collapse. In lieu of correcting the water damage, the medical center will install an access panel. Project will be completed by April 28, 2006. Ceiling tiles in the Intensive Care Unit that were damaged have been corrected as of February 16, 2006. The shower room floor tiles on the Long Term Care Unit that were broken have been corrected as of February 22, 2006. (c) A new patient wandering system was installed that controls both the doors and elevators. This was activated in January 2006. (d) In order to give the safety and sanitation rounds program top management, the Associate Director was designated as a team member in November 2005. To ensure tracking of deficiencies through the Safety Committee, the facility Safety Manager will conduct a quarterly review of all surveys conducted in the previous quarter. The Safety Manager will then report the findings of the review to the Safety Committee at the meeting scheduled the first month following the end of

the quarter. (e) All initial respiratory protection program training given to medical center staff was entered into the TEMPO program in January 2006. All future initial and refresher training will be entered into TEMPO as training occurs.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director requires that ISM staff monitor item usage rates and reduce excess medical supply inventory.

Concur **Target Completion Date:** Completed February 2006

Inventory Supply Management (ISM) staff monitor item usage rates on a recurring basis using the Generic Inventory Package (GIP); and, excess medical supply inventory has been reduced. In regard to the monetary benefits, we agree with the explanation of benefits but are unable to validate the amount of \$33,810 at this time.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) Revenue Section staff properly write-off uncollectible receivables, (b) the Resources Department Manager segregates agent cashier duties and accounting functions related to the management of receivables in FMS, (c) the Resources Department conducts audits of canceled receivables and supporting financial documentation, and (d) VA Police notify the OIG if any audits indicate that funds were diverted.

Concur **Target Completion Date:** (a) Completed December 1, 2005 and (b) Completed November 18, 2005

(a) The recommendation of writing off uncollectible receivables was implemented on December 1, 2005. (b) Segregation of duties was implemented on November 18, 2005. (c) Since November 2005 Altoona has gone back three years conducting a sample audit, the sample audit is ongoing and will be complete March 31, 2006; to date no problems have been found. Of note, the VISN Financial QM

was invited to Altoona to review processes and was unable to find any deficiencies. (d) Altoona concurs with the recommendation, however since November 2005 Altoona has been conducting an ongoing audit, this sample audit goes back three years and will be completed March 31, 2006; to date no problems have been found.

Recommendation 5. We recommend that the VISN Director ensure that the Medical Center Director requires that:

- a. The ISO includes all required information in the AIS contingency plan.
- b. IRM staff ensure computer automatic interactive-session time-out settings are working properly.
- c. The ISO promptly terminates LAN and VistA access for users who leave the medical center or who no longer need access.
- d. The ISO reviews LAN and VistA user access privileges at least every 90 days.
- e. Essential backup data is only stored in secure areas.
- f. The ISO reassesses position risk levels and completes required background screenings for employees assigned new IRM responsibilities.

Concur **Target Completion Date:** (a) May 19, 2006, (b) Completed November 2005, (c) Completed November 2005, (d) Completed November 2005, (e) Completed March 13, 2006, and (f) May 15, 2006

(a) The ISO and the Acting Chief, IRM are in the process of updating the medical center's AIS contingency plan to conform to VHA's new contingency plan template. The plan will include all requirements for backup tape retrieval procedures, damage assessment procedures, hardware and software inventories, lines of succession, and resource recovery priorities. (b) This problem was fixed prior to the IG staff leaving our facility. This problem was identified at the CBOC in Johnstown. The Acting Chief implemented a Domain Wide Group Policy Object (GPO) to activate an interactive session time-out setting for all systems. All other individual or intermittent issues with GPO are addressed, as needed, and resolved. (c) Immediately after the IG staff identified this problem, the ISO reviewed access of users in VistA and LAN and identified those users who were no longer working for the medical center and terminated the

user's access. The ISO now runs reports for VistA and LAN on a monthly basis to screen those users who have not used VistA/Network in the last 90 days and terminates user access, as necessary. All employees must clear through the ISO when leaving VA employment. Also, the Human Resource Service provides a bi-weekly report to the ISO on those employees who have left employment, and computer access is checked to assure the user was terminated. On a monthly basis, the ISO checks with the Education Office, Contracting Office, and Credentialing & Privileging Coordinator to check on students, contractors, consultants who no longer require computer access. Due to the actions being done by the ISO, this recommendation is no longer valid. (d) Immediately after the IG staff identified this problem, the ISO reviewed access of users in VistA and LAN and identified those users who were no longer working for the medical center and terminated the user's access. The ISO now runs reports for VistA and LAN on a monthly basis to screen those users who have not used VistA/Network in the last 90 days and terminates user access, as necessary. All employees must clear through the ISO when leaving VA employment. Also, the Human Resource Service provides a bi-weekly report to the ISO on those employees who have left employment, and computer access is checked to assure the user was terminated. On a monthly basis, the ISO checks with the Education Office, Contracting Office, and Credentialing & Privileging Coordinator to check on students, contractors, consultants who no longer require computer access. Due to the actions being done by the ISO, this recommendation is no longer valid. (e) A new process was documented in a standard operating procedure and staff educated on the new process on February 27, 2006. Subsequently, the process was revised again on March 13, 2006. The computer data backups are now stored in a locked, secure area in the Police Office before they are transferred to an off-site storage location. The Police Office is in a separate building from the computer and PBX systems. The office-site location is located at the CBOC in Johnstown. (f) The PD for the employee transporting the data backup tapes to the off site location is in the process of being updated to include the responsibility for the duty of transporting the data backup tapes. The functional statement for the charge nurse position at the Johnstown CBOC is being

revised to document the duty of properly storing the tapes in the safe. The employees transporting/receiving the data backup tapes now have a NACI investigation. The ISO and Chief, Human Resources Service will be reviewing the duties of the employees handling the data backup tapes and determining the appropriate background screening for them by reviewing VA Directive & Handbook 0710, Personnel Suitability and Security Program. In the meantime, processes are in place and documented in IT Operating Procedure #1 to transport the tapes in a locked container, with a numbered seal tag. Any tampering with the container would be detected by IRM staff.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
3	Better use of funds by reducing excess medical supply inventories.	\$33,810

OIG Contact and Staff Acknowledgments

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Acknowledgments	Julio Arias Frank Giancola Donna Giroux Henry Hoffman Nelson Miranda Shoichi Nakamura Carol Torczon Carin Wieters William Woods
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Appendix E

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.