



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Western New York Healthcare System Buffalo, New York

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 VA Western New York Healthcare System (system), Buffalo, New York. The purpose of the review was to evaluate selected system operations focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training for 161 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Results of Review

This CAP review focused on 11 areas. The system complied with selected standards in the following areas:

- All Employee Survey
- Colorectal Cancer Management
- Controlled Substances Accountability
- Quality Management Program

We identified seven areas that needed additional management attention. To improve operations we made the following recommendations:

- Improve the drainage system in the patient shower located on the substance abuse treatment unit.
- Establish a contingency radiology transcription plan, and monitor timeliness of fee-based radiology studies.
- Strengthen controls to improve oversight of the contracting activity and contract administration, avoid conflicts of interest, and recover lost revenue from the sale of radiopharmaceuticals.
- Improve VA radiologist productivity and reduce the cost of outsourced radiology services.
- Improve inventory procedures and controls for non-expendable equipment.
- Strengthen controls to ensure purchase cardholders comply with acquisition regulations for purchases exceeding \$2,500.
- Strengthen controls for information technology (IT) security.

This report was prepared under the direction of Ms. Katherine Owens, Director, and Ms. Jeanne Martin, Associate Director, Bedford Office of Healthcare Inspections.

OIG Comments

The VISN Director and the Healthcare System Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendix A, beginning on page 20, for the full text of the Directors' comments.) We will follow up on the implementation of planned actions until they are completed.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Healthcare System Profile

Organization. Located in Buffalo and Batavia, New York, the system consists of a tertiary care facility, a long-term care center, and seven community-based outpatient clinics located throughout central and western New York. The system is part of VISN 2 and serves a veteran population of 124,000 in central and western New York and northern Pennsylvania.

Programs. The system provides comprehensive outpatient, medical, surgical, psychiatric, and nursing home care services. Additionally, it has programs in physical medicine and rehabilitation, neurology, oncology, and dentistry. The Buffalo division has 123 hospital beds, 30 nursing home beds, and 24 substance abuse residential program beds. It is a referral center for cardiac surgery, cardiology, and cancer care. The Batavia division has 120 nursing home beds and 16 Post-Traumatic Stress Disorder beds.

Affiliations and Research. The system is affiliated with the State University of New York (SUNY) at Buffalo School of Medicine and Biomedical Sciences. It also has affiliations with SUNY and other university and college programs in nursing, dentistry, pharmacy, physical and occupational therapy, psychology, social work, speech pathology, and healthcare administration.

Currently, the system has 200 approved research projects with over 70 Principal Investigators. Major areas of research include oncology, endocrinology, orthopedics, and Alzheimer's disease. The system received national and international recognition for research in chronic obstructive pulmonary disease and tinnitus.

Resources. The medical center's budget in Fiscal Year (FY) 2004 was \$164.5 million and \$186.5 million in FY 2005. FY 2005 staffing was 1,673 full-time equivalent employees (FTE), which included 101 physician and 520 nursing FTE.

Workload. In FY 2004, the system treated 39,000 unique patients; in FY 2005 (through August), it treated 40,000 unique patients. In FY 2004, the average daily census was 240, and in FY 2005 (through August), the average daily census was 231. The FY 2005 (through August) outpatient workload was 516,663 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. We also followed up on recommendations made during the CAP review conducted in May 2000.¹ This review covered the following activities:

All Employee Survey	Information Technology Security
Colorectal Cancer Management	Laboratory and Radiology Timeliness
Controlled Substances Accountability	Quality Management Program
Environment of Care	Radiology Services
Equipment Accountability	Service Contracts
Government Purchase Card Program	

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

As part of the review, we used interviews to survey patient satisfaction with the timeliness of services and the quality of care. We interviewed 32 patients during the review and discussed the results with medical center managers.

During the review, we also presented three fraud and integrity awareness briefings for hospital employees. These briefings, attended by 161 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

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

¹ *Combined Assessment Program Review of VA Western New York Healthcare System*, Report Number 00-01230-120, September 25, 2000.

Results of Review

Opportunities for Improvement

Environment of Care – Drainage in a Patient Shower Needed To Be Improved

Condition Needing Improvement. System managers needed to establish adequate drainage in the patient shower located on the substance abuse residential treatment unit at the Buffalo division. The unit had a double shower stall separated by a wall that was approximately 5 feet high. The purpose of the wall was to provide patient privacy. The right side of the shower had a floor drain but the left side did not. Theoretically, because of the pitch of the shower floor, water from the left shower stall should draw off completely through the right shower drain. However, we observed standing water on the left shower stall floor on two separate days during the site visit. This condition created potential patient safety risks and infection control concerns. System managers agreed with the finding and began to develop a plan to place a drain in floor of the left side of the shower while we were on site.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director follow through with plans to improve drainage in the patient shower on the substance abuse residential treatment unit.

The VISN and the System Directors agreed with findings and recommendations. They reported that work has begun to install an appropriate drain. The action plan is acceptable, and we will follow up on the planned action until it is completed.

Laboratory and Radiology Timeliness – A Contingency Radiology Transcription Plan Needed To Be Established, and Timeliness of Fee-Based Radiology Studies Needed To Be Monitored

Conditions Needing Improvement. VISN and system policies defined timeliness standards for the completion of laboratory tests and radiology studies, and the system's laboratory tests and radiology studies generally met the standards set by the policies. However, system managers needed to establish a contingency radiology transcription plan and implement processes to ensure that fee-based radiology examinations were timely completed and reported to ordering providers.

Contingency Radiology Transcription Plan. The system's radiology transcription service was located in Florida. A delay in transcription of radiology study results occurred during the week of September 3, 2005, because of hurricane activity and damage in Florida. A second transcription delay occurred during the week of September 24, 2005, because the transcription company's computer server was not functioning; consequently, study results were not timely available to ordering providers during those 2 weeks. The

system had no contingency transcription plan in place to prevent transcription delays in the event the primary transcription service was temporarily unavailable.

Fee-Based Radiology Examinations. The system had no monitoring process in place to assure that ordering providers and the radiology department timely received radiology study results performed by fee-based providers. The system utilized a “Delinquent Radiology Film Report” to identify incomplete studies done in the system’s radiology department, and studies were determined to be “delinquent” when the results of the study were not available to the ordering provider. However, no such system was in place for fee-based studies. The system needs to develop a monitoring process that will assure that fee-based services are timely completed and reported to ordering providers.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the System Director: (a) takes action to establish a contingency transcription plan in radiology and (b) requires that processes be established and implemented to monitor the completion and timeliness of fee-based radiology examinations.

The VISN and System Directors agreed with the findings and recommendations. They reported that implementation of voice recognition technology has begun throughout the VISN. The implementation date is scheduled for June 2006. When the technology is fully implemented, the current transcription service, located in Florida, will become the system’s contingency plan if the new technology was temporarily out of service. Additionally, the system established monitoring processes to assure that fee-based radiology services are timely completed and reported to ordering providers. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts — Strengthening Controls Would Reduce Costs and Avoid Apparent Conflicts of Interest

Conditions Needing Improvement. System managers needed to improve contracting activity performance by strengthening controls to ensure that the head of the contracting activity (HCA), contracting officers (COs), and contracting officer’s technical representatives (COTRs) perform their responsibilities in accordance with the Federal Acquisition Regulation (FAR), the VA Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 10 contracts valued at \$11 million from a universe of 77 service contracts valued at \$51 million. We identified the following issues that require management attention.

HCA Performance. The HCA is responsible for implementing and maintaining an effective and efficient contracting program and establishing controls to ensure compliance with the FAR, the VAAR, and VA policy. The HCA did not ensure required contract reviews were conducted for any of the 10 contracts. The review and evaluation, typically conducted by the HCA, helps ensure the completeness and accuracy of solicitations and contract documentation packages and further ensures compliance with

the FAR, the VAAR, and VA policy. Tangible benefits were achievable had the HCA conducted contract reviews.

For example, a review would likely have disclosed that a follow-on contract awarded on January 1, 2004, with the facility's medical school affiliate lacked a provision to continue sharing revenue generated from the sale of radiopharmaceuticals to local facilities. Until December 31, 2003, revenue from the sale of radiopharmaceuticals was handled under a cyclotron/radiopharmaceuticals contract valued at \$1 million. The contract was awarded in March 1997 and, through extensions, was effective through December 31, 2003. Under the contract, radiopharmaceuticals were manufactured using a cyclotron and radiochemistry lab, 50 percent of which was owned by the VA (\$2 million estimated VA cost). The contract stipulated that the VA would receive a portion of the revenue derived from sales to local facilities. Since the end of the contract on December 31, 2003, the healthcare system had not received any portion of the revenue that the contractor continued to realize from the sale of the radiopharmaceuticals. The CO projected \$82,560 in annual revenue from the sale of the radiopharmaceuticals. Projected revenue from December 31, 2003, through September 30, 2005, could have been as high as \$144,480. We were informed that negotiations with the contractor for a revenue sharing follow-on contract were ongoing.

CO Performance. COs did not take action to forward sole source contracts with an affiliate to VA OIG for preaward audits, prevent apparent conflicts of interest, maintain complete files containing records of required preaward and postaward administrative actions, or ensure COTRs received training before assuming responsibility for monitoring contractor performance.

- *Preaward Audits of Sole Source Contracts.* VHA policy requires that sole source contracts with affiliated medical schools valued at \$500,000 or more be sent to the VA OIG Contract Review and Evaluation Division for preaward audits. The primary purpose of the audits is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. COs did not request preaward audits for the anesthesia and Positron Emission Tomography (PET) scan service contracts valued at \$4.5 million and \$809,000 respectively. We estimated that preaward audits would have resulted in cost savings of \$691,117.²
- *Apparent Conflict of Interest.* We determined that VA physicians and a VA technologist had apparent conflicts of interest involving contracts for anesthesia, PET scans, and gynecology/obstetrics services. The apparent conflicts of interest existed because these VA employees, who held paid and unpaid faculty appointments at the facility's medical school affiliate, participated in contracts with the affiliate and its associated practice group. Generally, if a VA employee has a faculty appointment

² The OIG has determined that preaward audits have historically resulted in potential savings of 21 percent of the total value of the proposed contract prices. The OIG has also determined that 62 percent of the potential cost savings has been sustained during contract negotiations. Applying these percentages to the total estimated value of the contracts (\$5,308,121 x 21 percent x 62 percent) resulted in estimated cost savings of \$691,117.

and receives any compensation, or is under the direction of the school, the VA employee has at least an imputed financial interest in the VA contracts with the school. No VA employee who has a financial interest, including an imputed financial interest, in the contract, may lawfully participate in the contract. VHA policy requires a written opinion from VA Regional Counsel that an affiliated employee may lawfully participate in the contract before participation occurs. In the contracts under discussion, the employees participated in the contracts without obtaining an opinion from VA Regional Counsel. In addition, VA policy requires that each VA physician receive a copy of VHA Handbook 1660.3 concerning conflicts of interest. Also the physician is required to sign VA Form 10-21009, acknowledging receipt of the handbook, and agree to abide by the guidance contained in the handbook. The VA physicians identified below as engaging in apparent conflicts of interest signed the acknowledgement forms in 2003, yet in 2004 and 2005 engaged in the apparent conflicts of interest. The apparent conflicts of interest could have been avoided if the contracting officers had determined that VA personnel were free of financial interest with contractors before allowing contract participation. In addition, physicians with the affiliate's associated practice group providing gynecology/obstetrics services self-referred services such as cervical repairs and hysterectomies without the approval of the system Director under the guidance of the Chief of Staff as required by the contract.

- a. **Anesthesia Services.** The CO inappropriately assigned an Administrative Officer, who lacked the technical expertise to evaluate the contractor's performance, as the COTR for this contract. At the request of the CO, a physician who held a paid appointment as an associate professor at the medical school, prepared and signed the annual "Contractor Performance Evaluation" for this contract. By signing the performance evaluation, which was part of the official file and used to determine if the contractor should be used for future contracts, he acted in the capacity of COTR. Because of his apparent conflict of interest, this physician may not act as the COTR, perform oversight or evaluation of contract performance, or review, certify, or approve any document of significance to the contract.
- b. **PET Scan Services.** Our review of this contract identified several conflict of interest issues. We found that the CO inappropriately assigned a VA nuclear medicine physician, who was an unpaid clinical assistant professor at the medical school, as the COTR for this contract. We also noted that the COTR improperly delegated the function of validating contract services received to a VA nuclear medicine technologist, who was an unpaid clinical instructor at the medical school. Additionally, the COTR delegated the responsibility to certify invoices to another physician who was a paid clinical associate professor at the medical school.
- c. **Gynecology/Obstetrics Services.** Contracted physicians with the affiliate's associated practice group had an apparent conflict of interest because physicians were allowed to self-refer services without the approval of the Chief

of Staff (COS) and the system Director. The CO included the following provision in the contract: “This contract allows the contractors to refer patients to themselves at an outside facility due to the inability of the VA facility to provide for some necessary procedures because of the lack of Gynecology/Obstetrics specific equipment and trained support staff. Due to the nature of the care being provided it is necessary to provide this continuum of care.” The contract stipulated that, “In order to prevent any abuse of this system the referrals will be approved by the Medical Center Director under the guidance of the Chief of Staff.” The COTR, the Women Veterans Clinical Manager, could not provide documentation showing four self-referrals, performed at a local hospital from January 2005 through November 2005, were approved by the system Director under the guidance of the COS as required. Further, the COS held a paid appointment at the medical school as an associate professor in the Department of Medicine; therefore, he was prohibited from providing guidance leading to approval. The CO needs to amend the contract to designate a non-affiliated VA physician the responsibility to provide guidance to the system Director, and the contract specification requiring the system Director approval needs to be enforced.

- *Required Preaward Administrative Actions.* COs did not conduct required preaward and postaward administrative actions including workload analysis to support the need and level of procurement for six contracts valued at \$5 million. Additionally, COs did not forward one contract valued at \$809,000 to the VA Office of Acquisition and Materiel Management for legal and technical review. COs did not search Excluded Parties Listing System (EPLS) database for six contracts valued at \$9.2 million to determine whether the prospective contractors were excluded from Federal contracts, and they did not maintain evidence of current liability insurance for three contracts valued at \$975,000. Price Negotiation Memoranda were not prepared for two contracts valued at \$989,000.
- *Required Postaward Administrative Actions.* COs did not conduct required postaward administrative actions including the initiation of background investigations of contract personnel with access to VA computer systems for two contracts valued at \$1.3 million. Additionally, they did not prepare written justifications before exercising option years for three contracts valued at \$1.5 million.

COTR Performance. For four contracts valued at \$4.4 million, COTRs inappropriately delegated their responsibilities to other VA employees, including some who had apparent conflicts of interest. COTRs for eight contracts valued at \$9.8 million did not receive training before assuming responsibility for monitoring contractor performance. The training explains COTR duties, responsibilities, limited authority, and prohibited actions, which include the delegation of validation and certification responsibilities.

See Appendix C, Page 34, for a table summarizing the types of contract services acquired, the estimated value of each contract, and contract administrative deficiencies noted.

Recommended Improvement Actions 3. We recommended that the VISN Director ensure that the System Director takes actions to: (a) conduct contract reviews to ensure compliance with FAR, VAAR, and VA policy; (b) recover revenue from the sale of radiopharmaceuticals manufactured using equipment half-owned by the system and negotiate a contract to ensure VA receives future revenue; (c) refer all sole source contracts (more than \$500,000) with an affiliate or its associated practice groups to the VA OIG for preaward audit; (d) prevent apparent conflicts of interest by determining that VA employees are free of financial interest with contractors before allowing contract participation, and if required, seek and abide by VA Regional Counsel's opinion; (e) correct the required preaward and postaward administrative deficiencies and strengthen controls and oversight to prevent deficiencies on future contracts; and (f) ensure COTRs understand their duties, responsibilities, and limited authority before assuming responsibility for monitoring contractor performance.

The VISN and System Directors agreed with the findings and recommendations. They reported that contract file reviews are being conducted, revenue from the past and future sales of radiopharmaceuticals will be recovered, and sole source contracts with the affiliate valued at more than \$500,000 will be referred to VA OIG for preaward audit. The three incidents identified in the review will be referred to Regional Counsel for a determination of conflict of interest and corrective administrative action will be taken on individuals who signed VA Form 10-21009 and did not comply with the guidance contained in Handbook 1660.3. In addition contract administrative deficiencies will be corrected where appropriate, all COTRs will receive COTR training specific to VA, and COs will meet with COTRs on a quarterly basis to discuss contract issues. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Radiology Services — The System Would Reduce Radiologists' Outsourcing Costs by Increasing Staff Productivity

Condition Needing Improvement. Increasing VA staff radiologists' productivity levels would allow the system to reduce outsourcing costs by as much as \$224,545 annually. The FY 2004 and FY 2005 average productivity levels for the system's VA staff radiologists were considerably lower than internal and external productivity benchmarks. The system was using contract and fee basis radiologists to provide services that could be performed by VA staff radiologists. The use of Relative Value Units (RVUs), a weighted measurement tool to measure radiologists' productivity, was not readily available to assess the productivity levels of staff and contract radiologists. The system can now utilize RVUs to monitor and measure productivity to ensure contract services are needed, minimize the productivity gap among staff radiologists, and maximize overall staff radiologists' performance.

Productivity Benchmarks. During March 2004, the Director of VHA's Radiology Program informed the OIG that there were no productivity standards for VA

radiologists,³ and he advocated the use of RVUs to assess their productivity.⁴ He stated that 5,000 RVUs would be the norm for full-time VA radiologists who have collateral administrative, educational, or research duties. Additionally, in the written summary of the January 14, 2005, National Monthly Radiology Conference Call, the Director of the VHA Radiology Program stated that the pay and RVU structure in the academic and private sector was as follows:

Academic Sector salary: \$271,000/5,500 RVUs = \$49.00 per RVU

Private Sector salary: \$345,000/7,100 RVUs = \$49.00 per RVU

There are various factors that can impact a VA radiologist's productivity, such as the lack of support staff, time involved with supervising or training residents, and medical equipment limitations. In assessing the healthcare system radiologists' productivity, we used 5,000 RVUs as a reasonable benchmark.

VA Staff Radiologists. In FY 2005, the system had 6.05 FTE staff radiologists (5 full-time and 2 part-time), of which 1.13 FTE had non-clinical duties. We used the 5,000 RVU benchmark to measure the productivity of the remaining 4.92 FTE staff radiologists with clinical duties. At the productivity level of 5,000 RVUs per FTE, the 4.92 staff radiologists would produce 24,600 RVUs. Our analysis of radiologists' productivity showed that in FY 2005, the 4.92 FTE staff radiologists produced 18,681 RVUs, for an average of 3,797 RVUs per FTE. We also noted that there was a considerable variation in productivity levels among the five full-time and two part-time radiologists. After subtracting time for indirect duties, we found that 4 radiologists had productivity levels below 3,100 RVUs per FTE; 2 radiologists were above 4,800 RVUs per FTE; and the remaining radiologist had a productivity level around 4,000 RVUs per FTE.

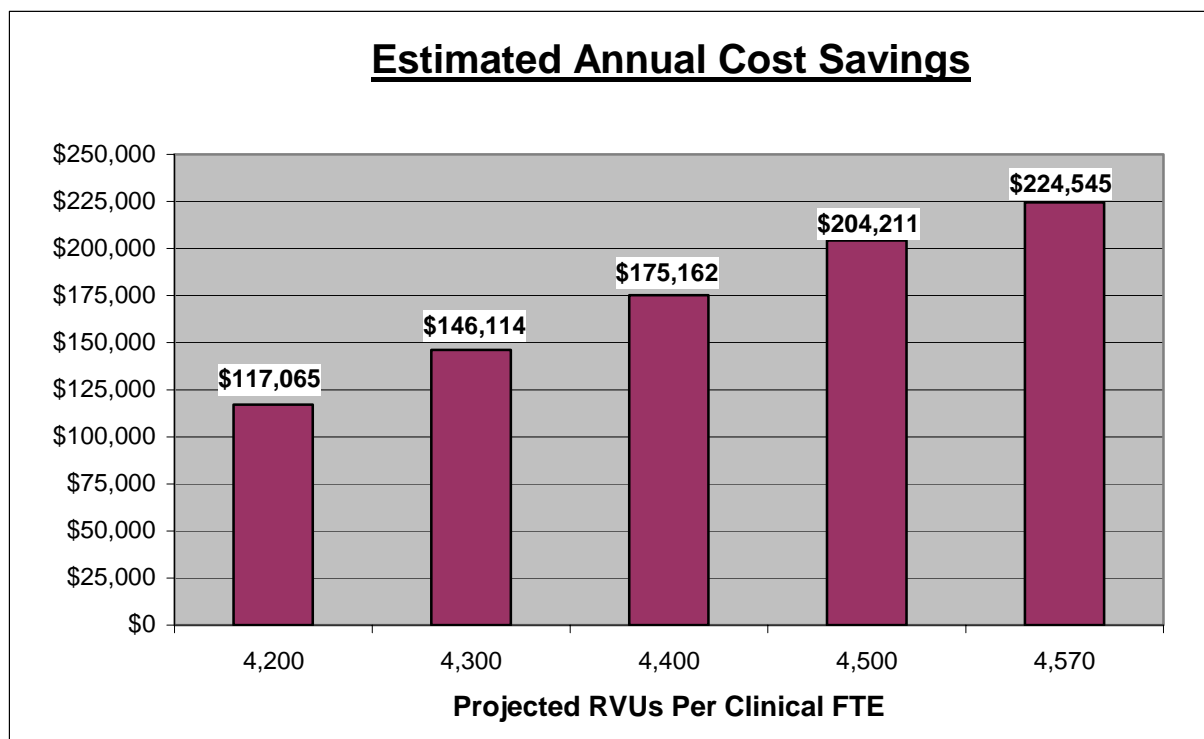
Outsourced Services. In FY 2005, the system outsourced radiologists' services through fee basis and a contract vendor. Our analysis identified that 3,963 RVUs were collectively outsourced for a total cost of \$224,597.

Monitoring the Usage of Outsourced Services. By increasing staff productivity closer to the 5,000 RVU benchmark, the amount of outsourced radiologists' services would be reduced, and the system could achieve substantial cost savings. The following graph shows an estimated annual cost savings that the healthcare system could achieve by increasing the average productivity levels of the 5.125 FTE current VA staff radiologists.⁵

³ See OIG Report No. 04-01371-177, issued August 11, 2004, *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*.

⁴ RVUs are numbers established by Medicare and used in its fee formula, along with practice and malpractice expenses. The RVU indicates the professional value of services provided by a physician. RVUs take into account calculations involving patients and procedures performed, along with the skill of the physician and the risk of the procedure.

⁵ The healthcare system's radiologist staffing level increased from 4.92 clinical FTE in FY 2005 to 5.125 clinical



The cost savings figures shown above are calculated⁶ by bringing previously outsourced services in-house and redistributing the workload to VA staff radiologists, thus increasing their productivity to the specified levels. At a productivity level of 4,570 RVUs per FTE, the 5.125 clinical FTE staff radiologists would be able to absorb the 3,963 RVUs that the healthcare system outsourced in FY 2005. The two staff radiologists who produced above 4,800 RVUs per FTE in FY 2005 are both full-time and account for an estimated 90 percent⁷ of the time radiologists spent training residents.⁸ Their productivity levels further support that 4,570 RVUs per FTE can be achieved to eliminate substantial outsourcing costs.

With the use of RVUs to monitor and measure staff radiologists' productivity levels, the healthcare system could save as much as \$224,545 in annual outsourced radiologists' services by increasing staff productivity to 4,570 RVUs per FTE. Additionally, the VISN is currently in the process of acquiring a commercial Picture Archive Communication System (PACS), which would further integrate radiology services and allow facilities to share resources. The investment in a commercial PACS at the VISN level would allow for radiology examinations to be digitally available for reading by all radiologists in the

FTE in FY 2006.

⁶ (Target Productivity – Current Productivity) x Current FTE x Outsourced Cost per RVU = Cost Savings
 (4,570 – 3,797) x 5.125 x \$56.68 = \$224,545

⁷ Healthcare system management estimated that radiologists spend 20 hours per week training residents. The two radiologists with productivity levels above 4,800 RVUs per FTE spend a combined 18 hours per week training residents.

⁸ Time spent training residents, which may or may not reduce productivity, is not deducted from clinical time because radiologists can still accumulate RVU credits for examinations completed by supervised residents.

VISN, regardless of their assigned location. This technology would allow radiologists resources to be shared among VISN facilities and further help eliminate future outsourcing costs of radiologists' services by distributing workload when out of balance conditions exist at individual facilities.

Recommended Improvement Action 4. We recommended that the VISN Director ensure the System Director takes appropriate action to (a) use RVUs to monitor and measure the department's workload, productivity, and costs and (b) improve VA staff productivity and reduce contract radiologists' costs.

The VISN and System Directors agreed with the findings and recommendations. They reported that the radiology workload will be monitored by using RVUs and weekly reports of these monitoring results will be generated. Plans to improve productivity and reduce radiology costs include the purchase and implementation of a PACS, reimbursing contract radiologists on a per study basis, and the addition of a Network radiologist position. The implementation 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. System managers needed to improve procedures to ensure that nonexpendable and sensitive equipment is properly accounted for and safeguarded. VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Materiel Management Service (A&MMS) staff are responsible for coordinating the EIL inventories, which included notifying all services when inventories were due and following up on incomplete or delinquent inventories.

As of October 25, 2005, the system had 184 active EILs listing 13,691 equipment items⁹ with a total acquisition value of about \$60.3 million. We identified six equipment accountability issues that required corrective action.

Equipment Inventory Controls and Procedures. VA policy requires responsible officials, such as service chiefs or their designees, to conduct annual or biennial inventories of nonexpendable equipment. These officials must evaluate the need for all equipment assigned to them and sign and date their EILs certifying that equipment was accounted for. We found the following equipment inventory deficiencies:

- We reviewed documentation for laptop computers that were on loan to VA employees and found that controls at the Buffalo campus were in place and working effectively to account for these items. However, at the Batavia campus, we found that controls were not in place and documentation was not maintained to account for laptops.

⁹ 2,223 items (of the 13,691) had an acquisition value of \$5,000 or more; the total acquisition value of the 2,223 items = \$46,972,582.

System managers informed us that Buffalo staff would work with Information Resource Management (IRM) employees at Batavia to implement proper controls to account for laptops on loan to VA employees.

- The 70 vehicles that the system leased through the General Services Administration were not recorded on an EIL. VA policy requires all equipment leased for 90 days or more to be listed on an EIL, including the monthly lease cost data for each item.

Accuracy of EILs. To assess accuracy of equipment inventory records, we reviewed a statistical sample of 99 equipment items¹⁰ (combined acquisition value = \$2,880,865). We identified the following accountability discrepancies:

- Nineteen items had the wrong locations listed in Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS), the property database.
- Four items had no location listed in AEMS/MERS.
- One item had no serial number listed in AEMS/MERS.
- We also found that the local process for replacing endoscopes affected the accuracy of the EIL for Surgical Service. When an endoscope was sent out for repair, a replacement was sent back instead of waiting for the repair to be completed. The serial number of the replacement endoscope was not updated on the EIL listing; therefore, the listing contained serial numbers of endoscopes that have since been replaced. We were unable to locate four endoscopes; however, it is likely that they were replaced and the proper adjustments were not made in AEMS/MERS to account for the replacements.

We concluded that the quality of the EIL inventories, as well as the accuracy and completeness of the property database, needed to be improved. Equipment cannot be properly safeguarded and accounted for without being accurately recorded on the appropriate EILs and in the property database. Responsible officials needed to do a complete inventory and physically verify all equipment listed on their EILs. Responsible officials should also review their EIL listings and report incomplete or inaccurate information (i.e., serial number, location) to A&MMS for correction in the property database. This review and physical verification of all items should be completed by the responsible officials before certifying the equipment as accounted for.

Sensitive Equipment. VA policy requires that certain sensitive equipment be accounted for regardless of cost, life expectancy, or maintenance requirements. Sensitive items, which include computer equipment, are subject to theft, loss, or conversion to personal use.

¹⁰ The 99 items were selected from the equipment list of nonexpendable property with each being acquired within the past ten years at a cost of \$5,000 or more.

As of October 25, 2005, the system had 5,637 pieces of IT related equipment (acquisition value = \$11,316,724), all of which were listed on IRM's EIL. Accounting for this equipment is also vital in safeguarding sensitive data.

To assess the accuracy of IT equipment inventory records, we reviewed a sample of 40 items (total acquisition value = \$67,082), of which we were unable to locate 5 (13 percent). Two of the items were desktop computers acquired in September 2003 for \$1,706 each; and the remaining three were laptop computers that did not have serial numbers, locations, acquisition costs, or acquisition dates listed in AEMS/MERS.

Controls needed to be strengthened to safeguard and account for all sensitive IT equipment and data. This included performing complete inventories, as well as making sure that information in AEMS/MERS (for example, location, serial number) was complete and accurate.

Out of Service Equipment. A&MMS staff did not determine whether 184 items (acquisition value = \$2,077,181) that appeared on the current property inventory list as "out of service," were appropriately listed in this category. System staff worked to reconcile the "out of service" list during our on-site review. A&MMS staff stated that about one-third of these items were building service equipment; however, an effort would be made to account for those items that did not fall under this category. A report of survey will need to be initiated for any "out of service" equipment items not located.

Disposed Equipment. We reviewed a sample of 15 items that had been disposed of (acquisition value = \$306,371) from a list of 4,322 disposed items (acquisition value = \$14,232,409) covering the period October 2003–September 2005, to determine if disposal documentation was adequate. A&MMS officials did not provide appropriate documentation for 2 of the 15 (13 percent) sampled items. One item was a printer acquired in 2004 at a cost of \$1,267, and the other was a computer acquired for \$1,500 (no acquisition date was listed in AEMS/MERS for this item). The Chief of IRM stated that these two items were probably disposed of, but proper documentation was not completed at that time. As a result, we were unable to verify the propriety of the disposal transactions for the two items noted above.

Access to Property Menu Options. Twenty-seven employees had the capability to add, edit, and turn-in (dispose) nonexpendable equipment in AEMS/MERS; 16 employees had the capability to add and edit items in the property database; and 3 had the option to edit data. We found that a review was needed to determine if the options for each employee were justified and ensure employee access is limited to those who need it.

Recommended Improvement Actions 5. We recommended that the VISN Director ensure that the System Director requires that: (a) documentation is prepared for loaned equipment at the Batavia facility; (b) all equipment leased for 90 days or more is entered into AEMS/MERS and listed on an EIL, including the monthly lease cost data for each item; (c) a process is established to track, document, and account for endoscopes that are

sent out for repair; (d) responsible officials physically verify all equipment and correct incomplete or inaccurate information, prior to signing their EIL inventories and certifying equipment as accounted for; (e) controls are strengthened to safeguard and account for all sensitive IT equipment; (f) controls are strengthened to account for property listed on the EIL as “out of service”; (g) disposal of equipment is properly documented; and (h) a review is conducted to make sure that access to the property database is restricted to employees with legitimate need.

The VISN and System Directors agreed with the findings and recommendations. They reported that Batavia IRM Service employees will be trained on loaned equipment controls and the necessary documentation, all equipment leased for 90 days or more will be entered into AEMS/MERS, and a process will be developed for tracking equipment that has been sent out for repair. EILs will be inventoried annually and the process will include 100 percent verification of all equipment listed, sensitive IT equipment will be added to the appropriate EILs and accounted for during the annual inventories, and listings of out of service equipment will be reviewed and updated annually. In addition, Logistics staff is developing a policy explaining the proper process for turn-in and disposal of equipment, and the list of employees with access to AEMS/MERS will be reviewed to ensure only those with legitimate need have access. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program — Compliance with the Federal Acquisition Regulation Needed To Be Improved

Condition Needing Improvement. System managers needed to strengthen controls to ensure that Government purchase cardholders seek competition for open market purchases exceeding \$2,500. For the period October 1, 2004, through September 30, 2005, the healthcare system had 123 cardholders; 42 approving officials processed 27,259 transactions valued at approximately \$18.8 million. We reviewed a sample of high dollar prosthetic items purchased on the open market to determine if cardholders were complying with the FAR requirement that cardholders document consideration of three sources for competition or document the justification for using a sole source vendor. We found that cardholders purchasing prosthetic supplies did not always maintain documentation to support competition for purchases exceeding \$2,500.

To determine if the system purchased supplies in accordance with the FAR, we reviewed 31 purchase card transactions consisting of prosthetic items valued at \$252,771. Seventeen purchases (55 percent) of scooter and wheelchair lifts valued at \$148,485 were made on the open market without documentation of bids from 3 sources or justification after using a sole source vendor. As a result, cardholders did not have reasonable assurance that the best prices were obtained or that these procurements were made in VA’s best interest. The remaining 14 prosthetic purchases valued at \$104,286 had documentation for 3 bids or sole source justification.

In our prior CAP Report dated September 25, 2000, we also noted that cardholders needed to comply with procurement competition requirements to ensure the Government receives the best available price. We recommended that cardholders seek competition to the maximum extent practicable when obtaining supplies or services. The Director concurred with the finding and provided an implementation plan to conduct specific training for those cardholders involved with ordering prosthetic items. This training did take place, but cardholders' action to seek competition was not being monitored for prosthetic equipment purchases.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the System Director requires cardholders to consider three sources of competition for purchases over \$2,500 or document the justification for using a sole source vendor.

The VISN and System Directors agreed with the findings and recommendations. They reported that spot check audits will be performed to ensure cardholders consider three sources of competition for purchases over \$2,500 or document the justification for using sole source vendors. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security — Controls Needed To Be Strengthened

Conditions Needing Improvement. System managers needed to strengthen information technology (IT) security. We evaluated IT security to determine whether controls and procedures were adequate to protect automated information systems (AIS) resources from unauthorized access, disclosure, modification, destruction, and misuse. We found that the healthcare system's Information Security Officer (ISO) made sure employees completed their annual security awareness training and had initiated appropriate full background investigations on applicable Information Resource Management (IRM) staff. Additionally, the automatic session timeout feature was enabled on all healthcare system workstations at the Buffalo campus. The following issues required management attention.

Access to AIS Resources. Physical access to AIS resources must be limited to only those personnel who have a legitimate need for access. At the Buffalo campus, access to both the computer room and telephone switch room were controlled by an electronic card reader. We found that 17 people without a legitimate need for access had electronic keys which allowed them access to these rooms. A key for both these rooms should be kept by VA Police Service, where it would be available in the event someone needed to enter one of the rooms in an emergency situation. Additionally, requiring the user to sign for the emergency key would improve control over access to these rooms.

At the Lockport CBOC, we found a VA computer left unattended without being properly locked down. Management should ensure all workstations at healthcare system locations are better protected by having the password-protected screensaver feature activated.

Physical Security. Proper controls and safeguards must be in place to protect AIS resources, including physical security of the computer room and all communication closets. One of the communication closets at the Buffalo campus had a window through which the contents of the room could be viewed. This window should be blocked to minimize the number of people who know where information systems are located.

At the Batavia campus, wiring from a communication closet was exposed at the top of the door. These exposed wires continued a short distance down the corridor and were vulnerable to damage. These wires should be concealed in protected encasement to better safeguard AIS resources.

At the Lockport CBOC, we found VA communication equipment located in an unlocked room, accessible to anyone who entered the CBOC. VA communication equipment at all CBOCs should be stored in locked cabinets to better protect them from destruction and misuse.

Hard Drive Sanitation. All sensitive information and data must be removed from hard drives prior to the disposal of computer equipment. We selected 15 computers that had been disposed of within the past 2 years, which we identified by their local inventory number. We requested documentation showing that the hard drives had been properly sanitized or destroyed prior to disposal. The hard drives are removed from the computers and stored within the IRM service area until they are destroyed by a contractor. Until recently, the local inventory number of the computer from which they were removed was not captured. IRM management could not provide any documentation for the 15 computers in our sample. Without proper documentation we could not be sure of the status of the hard drives. IRM management needs to establish written policies and procedures to control and track the status of computer hard drives through final sanitation and disposition.

Recommended Improvement Actions 7. We recommended that the VISN Director ensure that the System Director takes action to: (a) limit and control physical access to automated information system resources to only those with a legitimate need, (b) protect VA workstations at remote locations from unauthorized access, (c) block windows which allow people to view AIS resources, (d) protect the communication closet wiring at the Batavia campus from destruction and misuse, (e) secure and protect all VA communication equipment and wiring at remote locations, (f) establish written policies and procedures to control and track the status of computer hard drives through final sanitation and disposition, and (g) properly sanitize or destroy all hard drives prior to disposal and document this activity.

The VISN and System Directors agreed with the findings and recommendations. They reported that controls have been implemented to limit physical access to IT resources to those with legitimate need, CBOC staff have received additional training on protecting workstations from unauthorized access, and the window exposing IT equipment has been blocked. A study is underway to determine the feasibility of protecting the exposed wiring in a cost effective manner. In addition, locked cabinets will be installed to protect communication equipment at the Lockport CBOC. Computer property numbers will be recorded on hard drives to track them through final sanitation and disposal. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

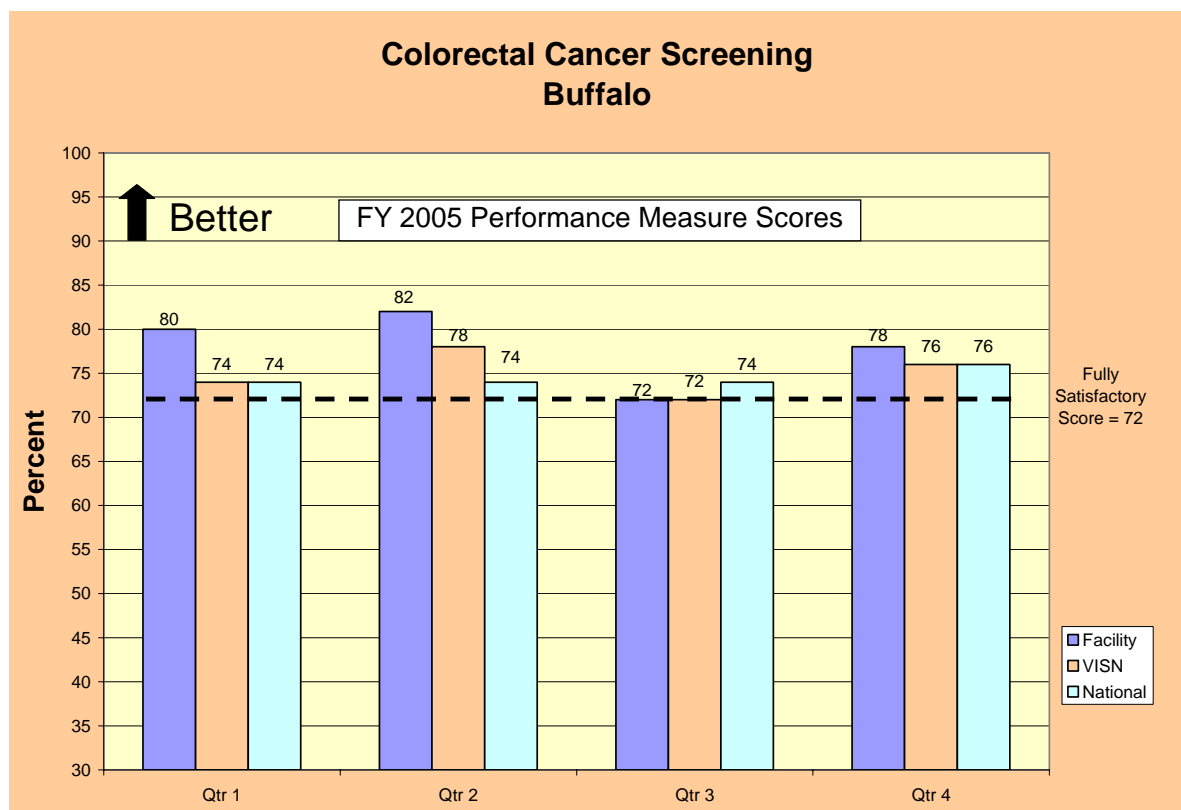
Other Observations

Colorectal Cancer Management – Processes Were Timely and Appropriate

The health care system met the VHA performance measure for colorectal cancer screening and provided timely Surgery and Hematology/Oncology consultative and treatment services. Three of 10 medical records reviewed revealed delays beyond the facility's 30-day goal for gastrointestinal (GI) consultative services; however, clinical managers provided sufficient documentation and detail to support the facility's attempts to rectify the causes for the delays. In addition, clinical managers promptly informed patients about their diagnoses and treatment options, and interdisciplinary treatment plans were developed.

Criteria. The VHA colorectal cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of 10 patients diagnosed with colorectal cancer during fiscal year 2005. To determine reasonableness of timeframes, we used the facility's 30-day goal for GI valuation (taking into consideration factors outside the facility's control).

Findings:



Patients appropriately screened	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatment
10/10	10/10	10/10	10/10

All Employee Survey - Improvement Plans Were Developed and Implemented

The Executive Career Field (ECF) Performance Plan for FY 2005 required that VISN directors ensure that the results of the 2004 All Employee Survey (AES) were disseminated throughout their networks during the FY 2005 rating period. In addition, VISNs were required to analyze the 2004 AES results and help facilities formulate improvement plans to address deficient areas. These plans were to include timelines and milestones that would effectively measure improvements.

The VISN and the system met the requirements of the ECF Performance Plan. The system's AES site coordinator distributed survey results through the system's website,

electronic mail, and service meetings; and system managers conducted town hall meetings. System managers developed measurable improvement plans based on an analysis of survey results and information gained through employee focus groups. Management's commitment to cultivating a supportive work environment was evident in the system's multi-level action plans to improve employee satisfaction.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 7, 2006

From: Director, VA Healthcare Network Upstate New York (10N2)

Subject: **VA Western New York Healthcare System Buffalo, New York**

To: Assistant Inspector General, Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. Attached is the response to recommendations noted in most recent Combined Assessment Program Review of the VA Western New York Healthcare System, Buffalo, New York, conducted in November 2005.
2. If you have any questions or need additional information, please contact Michael Finegan, Director, VA Western New York Healthcare System by calling (716) 862-8529.

(original signed by:)

WILLIAM F. FEELEY, M.D.

Attachment

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 7, 2006

From: Director, VA Western New York Healthcare System

Subject: VA Western New York Healthcare System Buffalo,
New York

To: Office of Inspector General

We concur with your findings and recommendations.

(original signed by:)

MICHAEL S. FINEGAN, M.D.

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the System Director follow through with plans to improve drainage in the patient shower on the substance abuse residential treatment unit.

Concur **Target Completion Date:** April 2006

Action Plan: Work has begun to install drain. Expected date of completion is the end of February.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the System Director: (a) takes action to establish a contingency transcription plan in radiology and (b) requires that processes be established and implemented to monitor the completion and timeliness of fee-based radiology examinations.

Concur **Target Completion Date:** June 2006

(a) Action Plan: Implementation of voice recognition technology is beginning in Network 2. This will be the main transcription mode for radiology reports. As such, the radiologist will dictate using the "Powerscribe" system (vender which has been selected) utilizing voice recognition and then can immediately verify/correct the transcribed report. Progress is being made to install hardware for Powerscribe. The Albany VA will be the test site due to issues regarding band width at Western New York. Quality assurance radiology tech has

received initial off-site training in January. When this system is fully implemented the current OSI transcription service will serve as back up to the Powerscribe system. Powerscribe will be available from a variety of work areas within the radiology department, for availability to not only staff and fee basis radiologists, but contract radiologists also. This will eliminate the problem of the contract radiologists having to utilize remote access to verify their transcription from the OSI contractor currently used.

Concur

Target Completion Date: June 2006

Monitoring initiated- December 2005

Network radiologist- March 2006

Voice recognition- June 2006

- (b) Action Plan: Based on the recommendations of the IG, the TAT (as a function of %transcribed/%verified within 48 hours) is measured each quarter. Since November 2005, the TAT for report verification by our contract radiologists has improved approximately 20 percentage points (from approximately 50% to 70% or approximately a 40% improvement). Although still not at the goal, we continually monitor their week to week performance by running the delinquent films list. This information is provided to the Radiology department manager and the care line manager who provide feed back to the contractors. Tangential to this, we have instructed the contract radiologists to read those films which have already gone beyond the 48 hours in an effort to 'catch up'. Upon implementation of the voice recognition transcription system "Powerscribe", the contract radiologists would be able to dictate through this system and eliminate the transcription delays which are inherent to the current OSI system. We continue to explore the feasibility of hiring a Network radiologist which could provide support to the Network 2 radiology departments from a remote site. This could reduce further the necessity for contract assistance.

Recommended Improvement Actions 3. We recommend that the VISN Director ensure that the System Director takes actions to: (a) conduct contract reviews to ensure compliance with FAR, VAAR, and VA policy; (b) recover revenue from the sale of radiopharmaceuticals manufactured using equipment half-owned by the healthcare system and negotiate a contract to ensure VA receives future revenue; (c) refer all sole-source contracts (more than \$500,000) with an affiliate or its associated practice groups to the VA OIG for preaward audit; (d) prevent apparent conflicts of interest by determining that VA employees are free of financial interest with contractors before allowing contract participation, and if required, seek and abide by VA Regional Counsel's opinion; (e) correct the required preaward and postaward administrative deficiencies and strengthen controls and oversight to prevent deficiencies on future contracts; and (f) ensure COTRs understand their duties, responsibilities, and limited authority before assuming responsibility for monitoring contractor performance.

(a) conduct contract reviews to ensure compliance with FAR, VAAR, and VA policy

Concur **Target Completion Date:** Audits will begin 1/16/2006 and will be ongoing

The Head of Contracting Activity (HCA) will implement an oversight program for reviewing contract files to ensure compliance with regulations and policy. The program will utilize a standardized contract file checklist as a tool to ensure compliance while documenting the results and any necessary corrective action. Results will be documented, summarized, and reported by the HCA to the Network Chief Logistics Officer and the facility Director on a quarterly basis.

(b) recover revenue from the sale of radiopharmaceuticals manufactured using equipment half-owned by the healthcare system and negotiate a contract to ensure VA receives future revenue

Concur **Target Completion Date:** 6/1/2006

A new agreement will be negotiated with the University of Buffalo. The CO will include a provision in the new

agreement for the facility to receive revenue generated from past and future sales of radiopharmaceuticals.

(c) refer all sole-source contracts (more than \$500,000) with an affiliate or its associated practice groups to the VA OIG for preaward audit

Concur **Target Completion Date:** 2/1/2006

The HCA will utilize VAF 90-2268, *Procurement Request Review for the Small Business Program & Contract Bundling*, to ensure that all sole source contracts (more than \$500,000) with an affiliate or associated practice group will be forwarded to VA OIG for preaward audit.

(d) prevent apparent conflicts of interest by determining that VA employees are free of financial interest with contractors before allowing contract participation, and if required, seek and abide by VA Regional Counsel's opinion

Concur **Target Completion Date:** 3/1/2006

The three incidents identified by the OIG will be referred to Regional Counsel for a determination as to whether there is a conflict of interest. Corrective administrative action will be taken on individuals who signed VA Form 10-21009, *Acknowledgment Form*, and did not comply with the guidance on conflict of interest contained in Handbook 1660.3. The HCA has developed a questionnaire designed to determine whether a VA employee participating in the contract process is free of any apparent conflict of interest. The conflict of interest questionnaire will be deployed in two phases. Phase 1 will focus on sending the questionnaire to existing COTRs assigned to monitor contracts with an affiliate or associated practice group. Depending on the responses, changes to COTR appointments may be necessary. Phase 2 will focus on using the questionnaire to determine whether VA employees participating in the solicitation, negotiation, award, or administration of new contracts are free of apparent conflicts of interest. If a VA employee has an apparent conflict of interest, the HCA will seek the written opinion of VA Regional Counsel prior to allowing contract participation.

(e) correct the required preaward and postaward administrative deficiencies and strengthen controls and oversight to prevent deficiencies on future contracts

Concur **Target Completion Date:** Corrections began 1/1/2006. Ongoing.

Where appropriate, deficiencies will be corrected. As previously mentioned, a standardized contract file checklist will be used to ensure preaward and postaward administrative actions are conducted and documented in accordance with regulations and policy.

(f) ensure COTRs understand their duties, responsibilities, and limited authority before assuming responsibility for monitoring contractor performance

Concur **Target Completion Date:** 2/15/2006

All COTRs will complete the COTR training specific to VA prior to assuming their responsibility to monitor contracts. All COs will meet with COTRs at the time of delegation of authority to ensure COTRs understand their duties and responsibilities and contract requirements. Thereafter, the CO will meet with the COTR in person or by teleconference/video conference on a quarterly basis to discuss contract issues and to ensure contractors are complying with contract terms, conditions, and requirements. Such meetings will be documented and included in the contract file.

Recommended Improvement Action 4. We recommend that the VISN Director ensure the System Director takes appropriate action to (a) use RVUs to monitor and measure the department's workload, productivity, and costs and (b) improve VA staff productivity and reduce contract radiologists' costs.

Concur **Target Completion Date:** 12/2005

(a) A weekly report is generated that monitors both the number of studies read and the number of RVUs generated by staff, fee basis, and contract radiologists. The standard productivity level of 5000 RVUs per FTE radiologist is being utilized for the benchmark. This has been further refined into weekly and daily RVU expectations for radiologists. The weekly productivity report is sent to all the staff radiologists,

Radiology Manager, Chief of Staff, Medical Center Director, Associate Medical Center Director, and Network D&T Care line Manager.

(b) The System has already experienced an increase in VA staff radiologists' productivity since applying RVUs to measure productivity and implementing the 5,000 RVUs per FTE standard described above. The System should also experience a further increase in productivity with the purchase and implementation of a commercial Picture Archive Communication System (PACS). The System will continue to identify ways to fully utilize staff resources to reduce the amount of contract radiologists' services needed. Additionally, the System reimburses contract radiologists per study. We will monitor the types of studies that are assigned to the contract staff and utilize contract staff for more plain films rather than the more costly specialized studies like MRI.

Contract radiologists continue to be used as a supplemental staffing alternative when staff radiologists are on leave or experiencing excessive workload. Currently, the Syracuse, Canandaigua, and Bath facilities are utilizing the services of a fee basis radiologist who can read studies either remotely through a PACS or actually go to the site where the staffing need exists. We are considering the possibility of making this a Network radiologist position covering any of the five medical centers and the two clinics which provide on-site radiology services. This would facilitate directing staffing to those sites which need it due to vacancy, leave, or increases in workload and further eliminate contract costs for the System.

Recommended Improvement Actions 5. We recommend that the VISN Director ensure that the System Director requires that: (a) documentation is prepared for loaned equipment at the Batavia facility; (b) all equipment leased for 90 days or more is entered into AEMS/MERS and listed on an EIL, including the monthly lease cost data for each item; (c) a process is established to track, document, and account for endoscopes that are sent out for repair; (d) responsible officials physically verify all equipment and

correct incomplete or inaccurate information, prior to signing their EIL inventories and certifying equipment as accounted for; (e) controls are strengthened to safeguard and account for all sensitive IT equipment; (f) controls are strengthened to account for property listed on the EIL as “out of service”; (g) disposal of equipment is properly documented; and (h) a review is conducted to make sure that access to the property database is restricted to employees with legitimate need.

(a) documentation is prepared for loaned equipment at the Batavia facility

Concur **Target Completion Date:** 3/31/2006

Buffalo IRM Service employees will train Batavia IRM Service employees on loaned equipment controls, processes, and documentation to be implemented.

(b) all equipment leased for 90 days or more is entered into AEMS/MERS and listed on an EIL, including the monthly lease cost data for each item

Concur **Target Completion Date:** 7/31/2006

A local equipment identification number (EE#) will be assigned to all leased vehicles and each will be listed on an appropriate EIL. The property database will be updated to include a monthly lease cost for all leased computer equipment where not currently listed.

(c) a process is established to track, document, and account for endoscopes that are sent out for repair

Concur **Target Completion Date:** 4/30/2006

The Logistics Office staff will work with Clinical Engineering to create a process to track equipment that is sent out for repair. There is currently no process in place to update AMES/MERS when equipment is sent to and returned from repair facilities.

(d) responsible officials physically verify all equipment and correct incomplete or inaccurate information, prior to signing their EIL inventories and certifying equipment as accounted for

Concur **Target Completion Date:** FY06 – ongoing.

Due to recent VA policy changes, EIL's will be inventoried annually. This process will include 100 percent physical verification of all equipment items listed on each EIL, as well as updating incorrect and incomplete data listed in AEMS/MERS.

(e) controls are strengthened to safeguard and account for all sensitive IT equipment

Concur **Target Completion Date:** 9/30/2006

A&MMS staff have begun adding all sensitive IT equipment to the appropriate EILs. This equipment will now be accounted for during the annual EIL inventories, thus improving controls to safeguard and account for all sensitive IT equipment.

(f) controls are strengthened to account for property listed on the EIL as "out of service"

Concur **Target Completion Date:** 9/30/2006

A&MMS staff will work with Batavia engineering staff to review and edit building service equipment items listed as out of service. A&MMS staff will also review and update the out of service listing to ensure that only proper items are included. In addition, Logistics staff will annually review and update a fileman report on out of service items.

(g) disposal of equipment is properly documented

Concur **Target Completion Date:** 6/30/2006

Logistics staff is in the process of developing a new local policy explaining the proper process for turn-in and disposal of equipment.

(h) a review is conducted to make sure that access to the property database is restricted to employees with legitimate need

Concur

Target Completion Date: 3/31/2006

The Logistics Manager and Equipment Manager will review the list of people with access to AEMS/MERS to ensure that only employees with a legitimate need have access.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the System Director requires cardholders to consider three sources of competition for purchases over \$2,500 or document the justification for using a sole source vendor.

Concur

Target Completion Date: (1) 2/1/2006
(2) 3/10/2006 (3) 1/31/2006

Action Plan:

1. Cardholders will consider three sources of competition for purchases over \$2,500.00 or have written documentation that supports sole source. Spot check audits will be performed monthly. Prosthetic card holders were reminded again that they must follow these requirements.
2. VISN Prosthetic Office will compile monthly listings of prosthetic cardholders with orders over \$2,500 that were purchased on the open market. The WNY Prosthetics Representative will review the listed cardholders' documentation to ensure that procurement guidelines are followed and report the results of the reviews in writing to the VISN Prosthetic Office within 15 days. Copies of this report will also be forwarded to the Financial Compliance Office for follow up of noncompliant prosthetic cardholders.
3. The Financial Compliance Office will conduct monthly sample reviews to include prosthetic and logistic purchases over \$2,500.

Recommended Improvement Actions 7. We recommend that the VISN Director ensure that the System Director takes action to: (a) limit and control physical access to automated information system resources to only those with a legitimate need, (b) protect VA workstations at remote locations from unauthorized access, (c) block windows which allow people to view AIS resources, (d) protect the communication closet wiring at the Batavia campus from destruction and misuse, (e) secure and protect all VA communication equipment and wiring at remote locations, (f) establish written policies and procedures to control and track the status of computer hard drives through final sanitation and disposition, and (g) properly sanitize or destroy all hard drives prior to disposal and document this activity.

(a) limit and control physical access to automated information system resources to only those with a legitimate need

Concur **Target Completion Date:** Completed 1/1/2006.

Facility Police have emergency access to the AIS areas because environmental systems are located there. There are checks and balances in place to assure that their emergency access is not abused. Control has been established to mitigate violations of AIS Security. These controls include the use of Personally Identified Key Cards with PINS, cameras, intrusion detection devices, and training. Future plans to move the environmental systems from the secured area will remove the need for facility police to have emergency access.

(b) protect VA workstations at remote locations from unauthorized access

Concur **Target Completion Date:** Completed 1/1/2006.

There were two unattended workstations observed during the walk through. The Lockport CBOC staff have attended IT Security Awareness Orientation and are current in VA Cyber Security training. This matter was discussed with the CBOC coordinator who immediately took action and provided additional training to the CBOC staff.

(c) block windows which allow people to view AIS resources

Concur **Target Completion Date:** 2/15/2006

One of the communications closets at the Buffalo campus had a window through which the information systems in the room could be viewed. Corrective action has been taken which consisted of placing dark paper over the inside of the window.

(d) protect the communication closet wiring at the Batavia campus from destruction and misuse

Concur **Target Completion Date:** 5/1/2006

IS management and Engineering staff will consult to see if it is physically possible to surround the exposed wiring in a cost effective manner; if not we should be able to accept this risk. The acceptance of this risk will be documented.

(e) secure and protect all VA communication equipment and wiring at remote locations

Concur **Target Completion Date:** 5/1/2006

At the Lockport CBOC, VA communication equipment was located in an unlocked room, accessible to anyone who entered the CBOC. Since this unlocked room cannot be locked, we will install appropriately sized lockable cabinets in this room.

(f) establish written policies and procedures to control and track the status of computer hard drives through final sanitation and disposition

Concur **Target Completion Date:** 1/1/2006

IS staff will now record the property number (EE#) onto the removed hard drive which will track the hard drive to the computer/device being exsessed. Procedures and controls will be put in place to track and document the status of computer hard drives through final sanitation and disposition.

(g) properly sanitize or destroy all hard drives prior to disposal and document this activity

Concur

Target Completion Date: 1/1/2006

The IS Operations Manager has made arrangements for all devices that have hard drives installed to be turned into IS for appropriate sanitization prior to disposal. This activity will be documented.

Appendix C

	<u>Anesthesiology Services</u>	<u>Radiation Therapy Services</u>	<u>PET Scanner Services</u>	<u>Radiology Diagnostic Services</u>	<u>Maintenance Services</u>	<u>Ambulance Services</u>	<u>Medical Waste Removal Services</u>	<u>Wheelchair Van Services (We Care)</u>	<u>Wheelchair Van Services (Able)</u>	<u>Gynecology/ Obstetrics Services</u>
<i>Contract Deficiencies</i>	\$4,499,021	\$3,500,000	\$809,100	\$525,000	\$376,810	\$346,000	\$316,350	\$250,000	\$200,000	\$180,000
<i>HCA Responsibilities</i>										
Contracts were not reviewed	X	X	X	X	X	X	X	X	X	X
<i>Contracting Officer Responsibilities</i>										
Apparent conflict of interest existed	X		X							X
Workload analysis not conducted		X		X			X	X	X	X
Preaward audit not conducted	X		X							
Legal/technical review not conducted			X							
Increase in price not supported by documentation		X								
EPLS search not conducted timely	X	X		X				X	X	X
PNM not prepared			X							X
Evidence of current liability insurance not in file				X				X	X	
Written justification to exercise option years not prepared			X		X		X			
Background investigations not conducted			X	X						
COTR letter not in file			X							
COTR not trained	X	X		X		X	X	X	X	X
<i>COTR Responsibilities</i>										
VA employees, other than COTR, reviewed and certified invoices		X		X				X		X

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
1b	Better use of funds by ensuring VA is properly compensated for sale of radiopharmaceuticals.	\$ 144,480
1c	Better use of funds by requesting preaward audits that would reduce contract prices.	691,117
2	Better use of funds by increasing VA radiologist productivity and reducing the cost of outsourced services.	224,545
	Total	\$1,060,142

OIG Contact and Staff Acknowledgments

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