Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Follow-Up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System Bay Pines, Florida

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VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG), Offices of Healthcare Inspections and Audit, conducted a review to assess the overall quality of care, and to follow up on *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, OIG Report No. 04-01371-177, issued August 11, 2004, to determine whether adverse conditions identified have abated, continued unchanged, or worsened, and whether OIG's recommendations were implemented. In addition, we reviewed new allegations related to alleged mismanagement at the Bay Pines Health Care System (BPHCS) in Bay Pines, Florida, alleged corruption and incompetence of BPHCS management, and an alleged substantial budget deficit affecting patient care at BPHCS.

We visited BPHCS during the weeks of March 6, March 13, and March 20, 2006. In general, quality management and other performance measures indicate that BPHCS delivers appropriate patient care. BPHCS managers implemented corrective actions that fully resolved or improved a majority of the deficiencies cited in the 2004 OIG report. However, despite significant BPHCS progress and achievements, we found that actions taken in some areas were not completely effective in resolving the conditions or that further action was needed. We found that:

- Mammograms were not interpreted in a timely manner.
- Immediate and urgent radiological examinations continue to be ordered inappropriately.
- Managers did not adequately monitor radiology productivity.
- Clinical service-level peer review processes were not functioning as outlined in BPHCS policy.
- Employees of the vendor that supports the DynaMed inventory management systems did not have background checks or security clearances.
- BPHCS staff did not adequately monitor the bulk oxygen system.

We found no evidence of mismanagement resulting in inadequate patient care, nor did we identify any examples of management corruption or incompetence. Overall, it is our opinion that conditions have substantially improved at BPHCS since March 2004.

Introduction

Purpose

At the request of Senator Bill Nelson and the Secretary of Veterans Affairs, the VA Office of Inspector General (OIG), Offices of Healthcare Inspections and Audit, conducted a follow-up evaluation of conditions identified in a 2004 OIG review at the facility. The purpose of the review was to assess the overall quality of care, and to follow up on *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, OIG Report No. 04-01371-177, August 11, 2004 (hereafter referred to as the 2004 OIG report), to determine whether adverse conditions identified have abated, continued unchanged, or worsened, and whether OIG's recommendations were implemented. In addition, we were asked to review new allegations made by an anonymous complainant related to alleged mismanagement at the Bay Pines Health Care System (BPHCS) in Bay Pines, Florida, alleged corruption and incompetence of BPHCS management, and an alleged substantial budget deficit affecting patient care at BPHCS.

Background

BPHCS, previously referred to as Bay Pines VA Medical Center (BPVAMC), is a large tertiary care system that provides medical, surgical, rehabilitative, and nursing home care to veterans in a 10-county area of southwestern and south-central Florida. BPHCS operates 461 beds, including a 104-bed domiciliary and 142-bed nursing home. It includes a large outpatient clinic (OPC) in Ft. Myers and seven community-based outpatient clinics in Avon Park, Dunedin, Ellenton, Naples, Port Charlotte, Sarasota, and St. Petersburg.

In February and March 2004, the OIG visited BPHCS in response to formal requests from the Secretary of Veterans Affairs and multiple Senators and Congressmen to evaluate the deployment of the CoreFLS and its effect on patient care, as well as other clinical and administrative issues. We addressed cancelled and delayed surgeries; Supply, Processing, and Distribution (SPD) Section deficiencies; VA's deployment of the CoreFLS; CoreFLS security controls; and CoreFLS contract procedures. We also evaluated the effectiveness of BPHCS leadership; Radiology Division backlogs, waiting times, and productivity; Neurosurgery Service consultations, waiting lists, and waiting times for outpatient care and services; Dermatology Service procedures; and cardiac catheterization complication rates. We confirmed many of the allegations and made recommendations for improvement. The 2004 OIG report can be accessed at http://www.va.gov/oig/52/reports/2004/VAOIG-04-01371-177.pdf

On February 8–9, 2006, articles appearing in the *St. Petersburg Times* highlighted new allegations made by an anonymous complainant that: (1) mismanagement at the hospital [BPHCS] has resulted in inferior care; (2) corruption and incompetence in BPHCS management has gotten worse; and (3) BPHCS is suffering a $20 million plus budget crisis, and implied that as a result, patients were being put on long waiting lists that were being misrepresented to Veterans Health Administration (VHA) headquarters. The Secretary of Veterans Affairs, prompted by congressional interest, requested that the OIG conduct a follow-up evaluation at BPHCS to review progress by the medical center in implementing OIG's recommendations made in our August 2004 report and to review new hotline allegations regarding the Veterans Integrated Service Network (VISN) 8 budgeting process and budget shortfalls.

Scope and Methodology

We visited BPHCS during the weeks of March 6, March 13, and March 20, 2006. Our primary focus was to assess the overall quality of care, to determine whether actions taken in response to the 2004 OIG report were implemented and effective, and to evaluate whether conditions had improved. (See Appendix A for details.) We interviewed employees, reviewed quality management (QM) and administrative records, and evaluated the medical records of select patients. We also assessed BPHCS patient and employee satisfaction scores, achievement of VHA performance measures, and response to the recommendations for improvement issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in June 2004.

We compared staffing and workload levels at BPHCS in the 1st Quarter Fiscal Year (FY) 2004 and the 1st Quarter FY 2006 to determine if there were any significant changes that might have impacted patient care. We conducted a staffing review of VA staff, contract, and fee-basis physicians at BPHCS to determine if the number and associated costs of these physicians appeared reasonable.

During the course of our review, numerous complainants made allegations of poor patient care practices and adverse outcomes, mismanagement, and questionable personnel practices. We followed up on and closed 12 complaints with no further action needed. (See Appendix B for details.) We did not address allegations related to personnel issues as they are more appropriately handled by Human Resource Management Service. Additional complaints related to cardiology were referred to our medical consultant for further evaluation.

One issue identified in the 2004 OIG report, *Issue 3: Contracting Procedures and Related Issues* (pages 45-76), as well as the recent complaint of a $20 million budget deficit, will be evaluated and reported under separate cover.

Evaluation Results

Issue 1: Quality of Care

In general, QM and other performance measures indicate that BPHCS delivers appropriate patient care and that conditions have substantially improved since March 2004. We reviewed staffing, workload, patient and employee satisfaction, and performance measure data to assess the overall quality of patient care. While workload has increased, staffing has also increased to meet demand. Patient and employee surveys reveal higher levels of satisfaction in comparison to 2004, and the facility has demonstrated progress in meeting or exceeding VHA's clinical performance measures. BPHCS is fully accredited by the JCAHO for the triennial cycle ending in June 2007.

Staffing Levels

Comparison of the Personnel and Accounting Integrated Data (PAID) system data extracts showed that 1st Quarter FY 2006 staffing levels for full-time and part-time physicians, surgeons, and nurses have **increased** since 1st Quarter FY 2004, as shown below:

	Increase
Physicians	34 percent
Surgeons	19 percent
Nurses [1]	37 percent

Our evaluation also showed that there is currently lower turnover in these positions than in the 1st Quarter FY 2004, indicating that BPHCS' ability to recruit and retain these staff has improved.

Workload Levels

Analysis of KLF[2] and Veterans Information System Technology Architecture (VistA) workload data extracts showed **increases** in inpatient, outpatient, and operating room (OR)/clinic workload levels as of the 1st Quarter FY 2006, as shown below:

- *Total Inpatients Treated* – **increased** about 11 percent in the 1st Quarter FY 2006 over inpatients treated in the 1st Quarter FY 2004.

- *Total Outpatients Treated* – **increased** about 14 percent in the 1st Quarter FY 2006 over outpatients treated in the 1st Quarter FY 2004.

[1] Nurses includes registered nurses, licensed practical nurses, nursing aides, and health technicians.
[2] KLF is the web site of the VISN Support Services Center, which generates reports of VA costs, staff time, and workload.

- *Combined Total OR Cases/Clinic Visits* – **increased** about 35 percent (OR cases up by 10 percent; clinic visits up about 25 percent) in the 1st Quarter FY 2006 over OR/clinic cases in the 1st Quarter FY 2004.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy.[3] VHA relies on the analyses, interpretations, and delivery of these survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. We compared BPHCS' SHEP data for FY 2004, FY 2005, and fiscal year to date (FYTD) 2006, which show improvement in all areas surveyed. Of particular note, patient perceptions of quality and timeliness in the following areas have substantially improved:

- *Outpatient Overall Quality* – **Increased** from 75.5 percent in the 1st Quarter FY 2004 to 83.6 percent in the 1st Quarter FY 2006.

- *Obtaining Timely Appointments for Established Patients* – **Increased** from 76.7 percent in the 1st Quarter FY 2004 to 89.4 percent in the 1st Quarter FY 2006.

- *Obtaining Timely Appointments for New Patients* – **Increased** from 62.6 percent in the 1st Quarter FY 2004 to 93.5 percent in the 1st Quarter FY 2006.

BPHCS also exceeded national averages in all areas surveyed. During the 1st Quarter 2006, the facility significantly exceeded national averages in obtaining timely appointments for both established and new patients.

Staff Satisfaction

BPHCS utilized All Employee Survey (AES) data to measure employee satisfaction. An Executive Career Field performance plan measure required VISN directors to analyze the employee survey results and develop an action plan to address areas in need of improvement. Although VHA administers an AES every 3 years to assess employee and organizational satisfaction, BPHCS chose to complete the survey in FYs 2004, 2005, and again in 2006[4] to ascertain the effectiveness of corrective actions and the impact on staff perceptions and satisfaction.

Comparison of the FY 2004 and FY 2005 AES results demonstrated some improvement in all 30 factors surveyed in FY 2005. The 13 factors measured by the Job Satisfaction Index showed more improvement in FY 2005 than did the 17 factors measured by the

[3] vaww.oqp.med.va.gov It should be noted that information referenced from this website is on a VA intranet site not available outside the VA system.
[4] These data have not yet been reported.

Organizational Assessment Inventory (OAI). However, Bay Pines OAI scores were not significantly different statistically from VISN or national means in FY 2004.

Following FY 2005 data analysis, the AES Action Planning Team held Town Hall meetings to disseminate the information and conducted 50 action planning sessions with Services or workgroups, which resulted in submission of 48 action plans to address employee satisfaction. The Team continues to monitor action plan implementation and hopes these efforts will result in further improvement in FY 2006 AES scores. These efforts indicate management has taken aggressive action to improve employee satisfaction.

VHA Performance Measures

VHA performance measures demonstrate a medical facility's compliance with clinical practice guidelines that are designed to achieve high quality health outcomes reliably and efficiently. Performance measures set national benchmarks for the quality of preventive and therapeutic health care services in areas such as myocardial infarction, diabetes, and chronic obstructive pulmonary disease. VHA uses comparative data from within the organization and from the private sector to hold managers accountable for less than optimal performance and to demonstrate best practices in health care delivery. We compared BPHCS' clinical performance measures from FY 2004, FY 2005, and FYTD 2006, which reflect consistent improvement across 17 of 20 like measures.[5]

Issue 2: Follow-Up to Previous OIG Recommendations

BPHCS managers implemented corrective actions that fully resolved or improved a majority of the deficiencies cited in the 2004 OIG report. BPHCS management had partial or total responsibility for implementing 11 of the 18 recommendations; other VA entities such as the VISN, the Office of Information and Technology, and the Office of Security and Law Enforcement, had responsibility for the remaining 7 recommendations. However, despite significant BPHCS progress and achievements, we found that actions taken in four areas were not completely effective in resolving the conditions or that further action was needed. See Appendix A for previous report recommendations, actions taken, and current status.

Radiology – Improvements Are Still Needed

The BPHCS Imaging Service is comprised of two divisions—Nuclear Medicine and Radiology. Imaging Service offers nuclear medicine, general x-rays, computerized tomography (CT) scanning, magnetic resonance imaging (MRI), ultrasonography, angiography, interventional radiological procedures, and screening mammography. In FY 2005, Imaging Service completed more than 123,000 examinations. According to

[5] Performance in two measures remained the same and declined in one measure (smoking cessation).

facility guidelines, STAT (immediate)[6] requests require an examination and interpretation within 1 hour. Urgent requests require the examination and interpretation within 2 hours. Routine requests require the examination within 30 days and image interpretation within 48 hours of exam completion.

In our 2004 OIG report, we noted that the Radiology Division (Radiology) of the BPHCS Imaging Service was neither scheduling exams nor interpreting and verifying images in a timely manner. In addition, we found that providers were ordering priority status exams unnecessarily, and managers did not appropriately manage Radiology resources. While Radiology had largely resolved delays in exam scheduling and image interpretation and verification, and had addressed one component of our resource management finding (see Appendix A), other conditions still existed, as follows:

Mammograms Were Not Interpreted in a Timely Manner

The facility had not adequately addressed the issue of delayed mammogram interpretations, and the condition, while much improved from 2004, still existed. From October 1–December 31, 2005, 466 mammograms were completed; however, radiologists did not interpret and verify 148 (32 percent) of those films within 48 hours in accordance with VHA performance measure standards.[7] Four of those exams had not been interpreted or verified for more than 2 weeks. The condition continued into the 2nd Quarter FY 2006. For example, during the period March 1–31, 2006, 69 (35 percent) of 196 mammograms were not interpreted and verified within 48 hours. The Acting Chief of Radiology told us that the primary radiologist assigned to read mammograms often waits for comparison films from private hospitals before interpreting new films, which can delay the process. He agreed, however, that the radiologist could read the mammograms and note in the record that comparison films were not available. The record could later be addended when comparison films were received.

STAT and Urgent Examinations Continue To Be Ordered Inappropriately

In our 2004 review, we found that physicians inappropriately classified Radiology requests as STAT or urgent because they believed it was the only way to obtain timely services for their patients. The VISN and Medical Center Directors took actions to improve access to radiology examinations, educate staff about appropriate usage of STAT and urgent designations, and periodically review STAT and urgent exam requests to determine compliance with policy. However, we found that although Radiology had implemented a system to review STAT and urgent exam requests, the system did not adequately track and identify possible trends of improperly designated exam requests.

[6] STAT is a medical term which comes from the Latin *statim*, the word for immediately.
[7] This measure requires 90 percent of exams to be interpreted within 48 hours.

Radiology now conducts monthly reviews of a sample of 20 STAT or urgent exams completed during the prior month to determine whether the designated urgency level was appropriate. However, based on our review of the radiological examinations with a STAT or urgent designation from October 1, 2003–March 9, 2006, requesting staff were still inappropriately classifying the urgency of radiology requests. Although the percentage of examinations ordered by the requesting provider for a future date, which is inconsistent with the STAT or urgent designation, decreased since FY 2004, at least 797 (7 percent) of the 11,651 STAT and urgent requested exams conducted as of March 9, 2006, were requested for a future date.

Table 1. STAT and Urgent Exam Requests

	FY 2004	FY 2005	As of 3/9/06
Number of STAT/urgent exams	15,328	17,864	11,651
Total exams with future desired date	1,566	1,212	797
Percent of exams with future desired date	10	7	7

Radiology should continue to periodically review STAT and urgent requests ordered for future dates and determine whether any trends can be identified by ordering physician, clinic location, exam modality, or other factors, and take corrective action, as necessary.

Managers Did Not Adequately Monitor Radiology Productivity

During our 2004 review, we found that radiologist productivity was not monitored and recommended that actions be taken to ensure Radiology develop workload and performance standards so that assets would be appropriately managed. The VISN and Medical Center Directors concurred with the recommendation and stated that workload and productivity standards for Radiology would be managed by measuring the number of relative value units (RVU)[8] that each radiologist had accrued over a period of time. In 2006, we found that although managers collected data on Radiology productivity, this data was not used to evaluate radiologists' productivity or make adjustments to workload.

During our 2006 review, we found that RVU reports were frequently obtained and provided to the Chief of Staff (COS) and the Acting Chief of Radiology. However, these results were not trended or analyzed to evaluate the radiologists' productivity. In 2004, the director of VHA's radiology program advocated the use of RVUs to assess radiologist productivity. He stated that 5,000 annual RVUs would be the norm for full-time VA radiologists who had collateral administrative, educational, or research duties. Since none of the BPHCS radiologists had approved education or research duties, and

[8] RVUs are weighted units of measurement that allow for a workload comparison between different procedure complexities and case mixes.

administration functions were primarily assigned to the Acting Chief of Radiology, we performed a workload analysis using 6,000 annual RVUs as a standard of productivity that might be reasonably expected from BPHCS radiologists. During briefings, the COS agreed that 6,000 RVUs would be a realistic goal for staff radiologists.

Using the 6,000 annual RVUs as an expected standard, we determined that the ratio of completed RVUs to the number of expected RVUs for all staff radiologists[9] has steadily declined from 86 percent in FY 2003 to 61 percent projected for FY 2006. Managers were unaware of these results because they had not trended or analyzed the RVU production; therefore, they had not determined reasons for the changes in RVU productivity or whether these reasons were acceptable. The table below shows the total RVUs[10] completed by the BPHCS staff radiologists and fee-basis radiologists.

Table 2. Radiology RVUs

Full Time Radiologists	**FY 2003**	**FY 2004**	**FY 2005**	**FY 2006 Projected[11]**
Total completed RVUs	24,540.92	23,306.39	21,906.74	21,999.62
Total Expected RVUs	28,630.09	28,630.09	28,714.90	36,000.00
Percentage of Completed/Expected RVUs	86%	81%	76%	61%
Fee-Basis Radiologists				
Total completed RVUs	6,942.29	6,883.95	9,049.57	14,905.97
Total Expected RVUs	4,709.67	6,244.37	7,428.85	11,922.95
Percentage of Completed/Expected RVUs	147%	110%	122%	125%

To assess possible explanations for less than expected RVU productivity by staff radiologists, we interviewed radiologists and attempted to analyze daily productivity. The analysis of daily productivity for the 1st Quarter FY 2006 showed that radiologists could be more productive. For example:

- One radiologist was paid for 8 hours on Friday, December 23, 2005, with no productivity identified. The weekly schedule showed the radiologist was on leave, but no leave was identified in the PAID system. The radiologist stated that this leave may not have been recorded in PAID because of an administrative oversight, but it would be corrected.

[9] These numbers did not include the Acting Chief, Radiology Service's productivity data.
[10] Based on a standard of 6,000 completed RVUs per year and pro-rated based on number of hours paid to the radiologist.
[11] We obtained RVUs as of February 2006 and projected by dividing the results by 5 months and multiplying for a 12-month period.

- One radiologist was paid for 10 hours on Wednesday, November 16, 2005; however, records showed productivity (15 ultrasounds, 7 CTs, 2 x-rays, and 1 abdominal fluoroscopy) from 9:30 a.m.–11:30 a.m. and 2:30 p.m.–5:30 p.m.

- One radiologist was paid for 8 hours on Tuesday, October 25, 2005, yet records showed productivity (22 x-rays) from 10:30 a.m.–12:30 p.m. and 1:00 p.m.–4:30 p.m.

The radiologists could not provide specific explanations for decreased annual RVUs, but most stated that they could not increase their productivity. As previously identified, productivity needs to be better monitored and evaluated to ensure that assets are appropriately managed.

Radiology has made substantial improvements in access and timeliness and has also improved capacity by adding new equipment and increasing operational hours and coverage. However, we were told of some morale problems within the division, primarily related to salary and benefits. We also noted that one of the radiologists has been functioning as the Acting Chief for more than 2 years because the facility has been unable to recruit a full time Chief of Radiology. Stability within Radiology is critical to efficient operations.

Recommended Improvement Action 1. The VISN Director should ensure that the BPHCS Director takes actions to ensure that Radiology:

a. Interprets mammograms within 48 hours and implements a system to assure that VA mammography reports are appropriately addended when comparison films are received.
b. Periodically reviews STAT and urgent requests ordered for future dates and determines whether any trends can be identified by ordering physician, clinic location, exam modality, or other factors, and takes corrective action, as necessary.
c. Monitors and evaluates productivity to ensure that assets are appropriately managed.

The VISN and BPHCS Directors agreed with the findings and recommendations and reported that a radiologist has been assigned to read mammograms daily, and new digital technology will improve the timeliness of interpretations. In addition, performance monitors have been devised to track the appropriateness of STAT and urgent exam requests. Results of the mammogram and STAT/urgent performance monitor results will be reported to the COS on a monthly basis. An RVU report detailing radiologists' productivity will be reviewed by the COS weekly. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Peer Review – Processes and Oversight Could Be Enhanced

Clinical service-level peer review processes were not functioning as outlined in medical center policy, *Peer Review for Quality Management*, dated March 2005. This policy requires a service-level criteria-based peer review process with quarterly reporting to the BPHCS Peer Review Committee. We found that:

- Neurology Service did not have a peer review process.
- Medical Service did not meet the intent of the policy as their process focused on documentation rather than quality of care.
- Mental Health Service had a peer review process in the past, but managers were unable to provide recent examples of completed peer reviews. Mental Health Service last reported peer review findings to the Peer Review Committee in the 3rd Quarter FY 2005.
- Surgery Service had a peer review process, but meeting minutes did not clearly document findings and actions taken for identified quality of care issues.

Interviews with clinical staff indicated a need for clearer guidance from BPHCS Quality Systems (local terminology for the QM Department) to verify that the process was functioning as required by policy. We found that Quality Systems staff developed a process for service-level quarterly reporting to the Peer Review Committee but had not ensured that reporting occurred. Without effective peer review processes and adherence to reporting requirements, BPHCS and clinical managers cannot be assured that peer reviews reflect patient care quality consistent with community standards.

Recommended Improvement Action 2. The VISN Director should ensure that the BPHCS Director requires clinical services to comply with the facility's peer review policy and that Quality Systems oversight is adequate to evaluate the effectiveness of the required peer review process.

The VISN and BPHCS Directors agreed with the findings and recommendations and reported that BPHCS policy on peer review has been revised and no longer requires service-level peer reviews. The current organization-wide peer review process meets VHA standards, and BPHCS Quality Systems staff have received training and staffing is adequate to oversee the process. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Security Controls – Vendor Background Checks Should Be Completed

Employees of the vendor that supports the DynaMed inventory management systems did not have background checks or security clearances. VA Directive and Handbook 0710 and Federal Information Processing Standards 201 require employees and contractors to have background checks and security clearances commensurate with the level of risk before access is granted to VA facilities and information systems. Because of the time and money invested in the transition to CoreFLS, BPHCS was approved to use DynaMed instead of the Generic Inventory Package used by the remainder of VHA medical centers. Confusion over actions taken when the CoreFLS project was cancelled and the fact that clearances had not been completed before CoreFLS became operational caused this condition.

Adequate contractor background checks and security clearances minimize the risk that individuals could alter data for personal gain or cause intentional or inadvertent destruction of VA information systems.

Recommended Improvement Action 3. The VISN Director, BPHCS Director, and VA Office of Security and Law Enforcement should ensure that the background clearance process is completed for employees of the vendor supporting DynaMed.

The VISN and BPHCS Directors agreed with the findings and recommendations and reported that new applications for background checks will be completed in June 2006 on staff responsible for supporting the local DynaMed contract. Those applications will be submitted to the VA Office of Security and Law Enforcement for processing. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Bulk Oxygen System – Oversight Needed Improvement

BPHCS staff did not adequately monitor the bulk oxygen system. The facility took appropriate actions to bring the bulk oxygen system into compliance with National Fire Protection Association (NFPA) requirements and the VHA patient safety alert issued April 5, 2004, as recommended in the 2004 OIG report. Additionally, the facility executed a memorandum of understanding (MOU) with the local oxygen vendor, obtained appropriate annual inspections, and installed a larger capacity reserve tank. The SPD section under Nursing Service had responsibility for daily monitoring of the tanks and management of the contract, and Engineering Service was responsible for the testing and maintenance of the oxygen alarm system. While BPHCS has made progress in their management of the bulk oxygen system, we identified the following staff development and policy issues:

- Despite recent training, SPD staff were unable to tell us the capacity of the reserve tank or what a normal pressure reading would be.

- The SPD employee responsible for recording daily oxygen tank levels did not know what the gauges measured. Additionally, the employee sometimes recorded the pressure readings (in pounds per square inch [psi]), rather than the levels (in inches), as required.

- The guidance on when to order oxygen refills and when low-level oxygen alarms should sound was inconsistent.

We also identified a safety and security deficiency. We observed employees smoking within 20 feet of bulk oxygen tanks. The 2005 Annual Workplace Evaluation noted an "Imminent Danger Situation" when it identified BPHCS staff smoking near the oxygen cylinders stored near the warehouse loading dock. The bulk oxygen tanks are also in this area. Signs posted on the fence surrounding the bulk oxygen tanks clearly stated that no smoking was permitted within 50 feet of the tanks.

In addition, the fence surrounding the bulk oxygen tanks did not adequately secure the tanks, fill port, and access valves. The gate was padlocked but not fixed to the ground and could be pushed in far enough while still locked to allow access to the fill port/access valve.

The BPHCS Associate Director was informed of these conditions and provided an acceptable corrective action plan to improve the overall management of the bulk oxygen program. Actions included (1) transfer of program responsibility from SPD to the Director of Safety, (2) development of a competency checklist and increased training, (3) update of procedures, (4) strict enforcement of "no-smoking" around tanks, and (5) extending the perimeter fence. As BPHCS implemented immediate corrective actions, we made no recommendations.

Issue 3: Alleged Mismanagement Resulting in Inferior Patient Care

We did not substantiate the allegation that mismanagement had resulted in inferior patient care. As the complainant did not provide any specific examples of mismanagement that negatively affected patient care, we relied on staffing, workload, and performance data to assess the overall quality of patient care. As noted in Issue 1 on pages 3–5 of this report, we found that BPHCS generally showed improvement in scores from 2004 to 2006 or were actively meeting patient care performance standards.

Issue 4: Alleged Corruption and Incompetence

We did not substantiate the allegation that corruption and incompetence in BPHCS management has gotten worse, presumably in comparison to the management team in place in 2004. As the complainant did not provide specific examples of corruption and/or incompetence, we made our determination based on management's role in correcting previously identified deficiencies and actions taken to provide an atmosphere conducive to the delivery of high quality patient care. We found that, generally, deficiencies noted in our 2004 OIG report were corrected. In addition, we found that executive managers had instituted multiple initiatives to improve employee morale (see AES results, Issue 1) and promote high quality patient care (see SHEP scores and performance measure results, Issue 1). We found no evidence that executive managers were corrupt, dishonest, or incompetent; we found these managers to be experienced, knowledgeable, and responsive.

Conclusion

In the past 2 years, BPHCS managers have taken aggressive corrective actions and a majority of the conditions identified in the 2004 OIG report are improved or resolved. We noted that some deficiencies in Radiology, peer review, information security, and bulk oxygen system oversight still needed management attention.

We found no evidence of mismanagement resulting in inadequate patient care, nor did we identify any examples of management corruption or incompetence. As evidenced by SHEP, AES, and performance measure scores, BPHCS performance has continued to improve in virtually all areas. While we did speak with some employees who expressed dissatisfaction with management decisions and the way patient care is delivered, it is our opinion that conditions are better, not worse, at BPHCS.

(original signed by:)
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Assistant Inspector General for
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Appendix A

Follow-Up Evaluation of Clinical and Administrative Issues
Bay Pines, FL
Project No. 2006-01217-HI-0305

The following matrix shows the primary issues and recommendations as identified in the 2004 OIG report, and the current status of those conditions and recommendations.

REPORT ISSUES	2004 OIG REPORT RECOMMENDATIONS	STATUS As of March 2006	ACTION(S) TAKEN
Issue 1: Clinical Management and Administration			
Turnover in Key Leadership Positions Contributed to Dysfunctional Management.	**Recommendation 1:** The Deputy Under Secretary for Operations and Management needs to ensure that the VISN formulates, reviews, and implements action plans to improve the leadership and ensure a "Culture of Safety" at the BPVAMC.	**Condition Improved**	Key leadership positions have been filled, which appears to have had a stabilizing influence on most hospital operations. The nursing turnover and vacancy rates at BPHCS are better than state and national averages. From 2004 to 2006, there has been an increase in physicians and nurses of 34 and 37 percent, respectively. The BPHCS Safety Policy meets the intent of the VHA Directive outlining safety objectives and requirements. However, the 2001 policy is outdated and is currently being revised. The BPHCS Quality Systems Department's process for reporting, evaluating, correcting, and following-up on adverse events and other identified deficiencies is adequate.
Absence of Productivity Standards Contributed to Clinical Backlogs.	**Recommendation 2:** The Acting Under Secretary for Health in conjunction with the Deputy Under Secretary for Operations and Management needs to develop and implement productivity standards for physicians as directed by Public Law 107-135.	**Condition Improved**	The VHA Physician Productivity and Staffing Advisory Group has developed an RVU-based model for measuring productivity of medical and surgical specialty physician providers. Work is nearly complete on the development of a national specialty physician database to accurately define the physician workforce. Directive 2005-057 "Physician Labor Mapping," was published on December 1, 2005, and provides guidance to ensure more consistent utilization of the Decision Support System throughout VHA. The Advisory Group and the VHA Chief Consultant in Radiology are currently in the process of finalizing a national VHA directive "Guidance on

			Productivity and Staffing in Imaging Services." An additional 15 specialties (outpatient based medicine specialties and the specialties within Surgical Service) are currently being analyzed, with expected completion in the first half of calendar year 2006.
Senior Leadership Did Not Have a Formal Administrative Executive Board (AEB) Process in Place.	**Recommendation 3a:** The Director, VISN 8, in conjunction with the Medical Center Director, needs to ensure that BPVAMC resumes a formal AEB, or similar administrative committee structures, that documents senior management discussions, decisions, action plans, and solutions.	**Resolved**	The AEB has met for over 12 months as evidenced in meeting minutes. The minutes are detailed, concise, and reflect appropriate topic discussions with documented plans of action. Attendance records reflect participation by Board members.
The Former Chief, Medicine Service Created a Hostile Work Environment and Misused Funds Donated to the VA-Affiliated Research Corporation.	**Recommendations 3b – 3c:** The Director, VISN 8, in conjunction with the Medical Center Director, needs to: b. Request that The Bay Pines Foundation, Inc. bill the former Chief of Medicine $8,905 to recoup funds donated for a "mini-medical school" program, which he improperly spent. c. Take appropriate action against two employees who approved the use of grant funds from Pfizer, Inc. for not ensuring The Bay Pines Foundation, Inc. furthered the interests of the Department and its research and education programs, and for not complying with the terms of the grant letter.	**Resolved** **Resolved**	b. A bill of collection was issued to the former Chief of Medicine on February 7, 2005. c. One of the responsible employees retired on January 7, 2005, before administrative action was taken. The second employee was issued a letter of administrative action.
Managers at the Ft. Myers Satellite Outpatient Clinic (SOC) Cancelled	**Recommendation 3d:** The Director, VISN 8, in conjunction with the Medical Center Director, needs to require Ft. Myers SOC schedulers to	**Resolved**	Those veterans who had their appointments canceled 2 years ago were scheduled for audiology appointments with fee basis providers. The fee-basis contract remains in effect to handle any excess audiology workload

Audiology Appointments for Non-Service Connected Veterans. Ft. Myers SOC Managers Understated the Waiting List. Service-Connected Veterans Did Not Receive Audiology Appointments Within 30 Days.	enter initial audiology appointment requests as "next available" appointments and return visits as other than next appointments.		that may occur in the future. Ft. Myers reduced their waiting list to zero by expanding their audiology program from one full time (FT) and one part time audiologist to four FT audiologists. They added two sound booths to the one they already had to accommodate the additional audiologists. Priority veterans (those who are service connected 50–100 percent or are service connected for hearing) were seen within an average of 18.2 days, and all other veterans were seen within an average of 48.6 days. The waiting time met all performance measure standards, and schedulers were correctly entering appointments.
The Facility Bulk Oxygen System Was Not Properly Managed.	**Recommendations 3e – 3j:** The Director, VISN 8, in conjunction with the Medical Center Director, needs to:		
	e. Promptly resolve the bulk oxygen system deficiencies and brings the system into compliance with NFPA-99, NFPA-50 requirements, and the VHA PSA.	**Resolved**	e. The system was brought into compliance with NFPA requirements and with the VHA Patient Safety Alert of April 5, 2004. A qualified third party expert conducted an alarm set point verification on June 14, 2004, and the facility now has two independent 24/7 and constantly attended monitoring stations (energy center and telephone operator room) provided for all alarm conditions related to the Oxygen Utility System.
	f. Establish a Memorandum of Understanding (MOU) with the local oxygen vendor that includes all the requirements of the National Acquisition Center (NAC) contract.	**Resolved**	f. An MOU with Aire Liquide Healthcare America Corporation was signed on June 10, 2005. The MOU contains all the requirements of the NAC contract.
	g. Establish procedures to monitor oxygen level readings and conduct routine site inspections	**Condition Improved**	g. Although the facility established procedures to monitor oxygen level readings and conduct routine site inspections, we had concerns that the individuals assigned to these tasks did not possess the necessary knowledge to perform the functions. (See pages 11–12 for details.)

	h. Provide and document training to employees responsible for maintenance of the facility bulk oxygen system.	**Resolved**	h. The vendor provided training to employees responsible for the maintenance of the bulk oxygen system. This annual training was performed in June 2005 and was not due to be provided again by the time of our site visit.
	i. Obtain annual inspections of medical gas systems conducted by a qualified representative of the equipment owner.	**Resolved**	i. Annual inspections of the medical gas systems were conducted by the vendor.
	j. Install a larger capacity reserve tank.	**Resolved**	j. The facility installed a larger capacity (900 gallon) reserve tank to replace the 300 gallon reserve tank on August 5, 2004.
The Former Chief, Medicine Service, Misused Funds Donated to the VA-Affiliated Research Corporation.	**Recommendation 4:** The Deputy Under Secretary for Operations and Management needs to take appropriate administrative action against the former COS for not adequately supervising the former Chief, Medicine Service's, spending of Pfizer, Inc. grant funds.	**Resolved**	The former COS transferred to another VA medical center as a staff physician, thus taking a position downgrade and reduction in pay. These actions constituted appropriate administrative discipline.
Issue 2: Care in Selected Clinical Services			
Elective Surgery Backlogs Existed in Several Surgical Specialties.	**Recommendation 5:** The VISN Director needs to ensure that the BPVAMC Director completes a comprehensive review of the Surgery Service, including surgical subspecialties, to ensure timely delivery of surgical care.	**Condition Improved**	The facility took action to improve access to surgery services. As of March 2006, average wait times for general and vascular surgery, podiatry, and ophthalmology all fell within the established 30-day time frame. Orthopedics and urology had significantly reduced their average wait times for elective surgeries and were close to meeting the 30-day standard; average wait times for orthopedic and urologic surgeries were 38 and 35 days, respectively. Orthopedics has added a fee basis surgeon to the staff who will review consults as well as perform surgery. Currently, urology has only one surgeon who performs major urological procedures. The Chief of Surgery is actively recruiting for a Chief of Urology but has been unsuccessful to date. In addition, both orthopedics and urology will have additional OR time starting in April 2006. An otolaryngology surgeon will be on extended leave, freeing up additional OR slots for other specialties.

Radiology Service Waiting Times for Routine Examinations Exceeded 30 Days. Radiology Waiting Times for Image Interpretation Were Unacceptable. Mammograms Were Not Interpreted in a Timely Manner.	**Recommendations 6a – 6d:** The VISN Director, in conjunction with the Medical Center Director, needs to: a. Ensure that radiographic examinations are scheduled and images are interpreted within required time frames	**Condition Improved**	a. Average waiting times for routine CT, MRI, and ultrasound exams fall within the established 30-day timeframe. As of March 31, 59 MRI requests exceeded the 30-day standard; however, the MRI machine was out of service for more than 2 weeks in February 2006, which may explain these outliers. The BPHCS has instituted extended hours to address MRI demand and is evaluating the feasibility of purchasing a second MRI scanner to be installed in late FY 2007. The average turnaround times for image interpretation and verification for the above exams generally fell within the established 2-day timeframe. However, mammograms are still not being interpreted and verified within an acceptable timeframe. (See page 6 for details.)
Stat and Urgent Examinations Were Inappropriately Ordered.	b. Ensure that providers properly designate the urgency of radiological study requests.	**Unresolved**	b. The periodic review of cases designated STAT and urgent was implemented. Radiology service staff reviewed 20 STAT or urgent exams completed during the prior month. However, requesting staff was still inappropriately classifying the urgency of radiology requests. Although, the percentage of STAT and urgent examinations ordered by the requesting provider for a future date, which is inconsistent with the STAT or urgent designation, decreased since 2004, at least 7 percent of the STAT and urgent requested exams conducted as of March 9, 2006, were requested for a future date. (See pages 6–7 for details.)
Managers Did Not Adequately Monitor Radiology Service Productivity.	c. Ensure that radiology service develops workload and performance standards so that assets may be appropriately managed.	**Unresolved**	c. We found that the RVU reports were frequently obtained and provided to the Chief of Staff and the Acting Chief of Radiology. However, these results were not trended or analyzed to evaluate the radiologists' productivity. Using the 6,000 annual RVUs as an expected standard, we determined that the percentage of completed RVUs to the number of expected RVUs for all staff radiologists has steadily declined from 86 percent in FY 2003 to 61 percent projected for FY 2006. In contrast, the in-house fee radiologists' RVUs have ranged from 110 percent–147 percent of expected productivity based on the number of hours worked. Managers were unaware of these results because they had not trended or analyzed the RVU production, and therefore had not determined whether the reasons for the RVU productivity were acceptable. (See pages 7–9 for details.)

	d. Ensure that Radiology Service quality improvement plans encompass the interpretation of x-rays performed under contract.	**Resolved**	d. The Acting Chief of Radiology daily reviews the reports for the previous night's exams that were completed by the contractor. In addition, a minimum of 10 blind over-reads are reviewed monthly by radiology staff.
Clinical Leadership Did Not Ensure Timely Neurosurgery Access.	**Recommendation 7:** The VISN Director should ensure that the BPVAMC Director establishes a clear and effective referral mechanism for obtaining timely inpatient, outpatient, and emergency specialty and subspecialty service consultation for specialties not inherent to the facility.	**Resolved**	The James A. Haley VAMC, Tampa, FL, is the primary referral center for BPVAMC patients needing neurosurgery (NS) services. There are also contracts with two local hospitals for neurosurgical services. Since 2004, BPVAMC hired a neurosurgeon 1 day per week to evaluate the appropriateness of neurosurgical consult requests and assure pre-requisite testing and exams are completed prior to referral. Records show that between March 7, 2005–February 17, 2006, 166 NS consultation requests were completed and 44 were still pending. We reviewed 12 of the 44 pending cases and found documented clinical activity (progress notes or scheduled appointments), or found that patients either cancelled or no-showed for appointments. Our review of three specific cases brought to our attention by BPVAMC medical staff did not reveal delays in obtaining NS services.
Pulmonary Service Did Not Provide Timely and Adequate Services. Pulmonary Clinic Cancellations. There Were Long Delays in Diagnosing Lung Cancer.	**Recommendation 8a – 8c:** The VISN Director should ensure that the BPVAMC Director: a. Clearly enunciates the priority of patient care over possible competing endeavors to ensure that veterans receive timely appropriate care. b. Reinforces physician staff time and attendance requirements and require each physician to certify that they are aware of VA policies on the granting of leave and days off.	**Resolved** **Resolved**	a. The facility has taken actions to improve services and has added another pulmonologist and a nurse practitioner to Pulmonary Service. For January–February 2006, there were 39 scheduled appointments; none of the clinics were canceled for any reason. b. The pulmonologists work 40 hours per week, which sometimes includes 4-hour shifts each Saturday and Sunday. When providing scheduled coverage of the ICU on weekends, pulmonologists do not work the Friday before.

	c. Develops a process to ensure timely diagnosis of suspicious lung lesions.	**Resolved**	c. In general, the time from suspicious lesion to definitive diagnosis is 30 days or less (the facility goal). Delays are generally due to patient no-shows or physician determination to follow with regularly scheduled x-rays.
Ineffective Management of Patients Requiring Sleep Studies.	**Recommendation 9:** The VISN Director should ensure that the Medical Center Director establishes practice guidelines to ensure that patients receive timely and appropriate consultation when a sleep disorder is suspected.	**Condition Improved**	While the number of patients awaiting sleep studies has increased from 476 in 2004 to 639 in 2006, full implementation of corrective actions initiated within the past 10 months should reduce the waiting list. Those initiatives include: • Developed guidelines for sleep study consultations and sleep disorder treatments. • Opened a 2-bed sleep lab at BPVAMC in December 2005; 2 additional beds should be activated by late April 2006. These beds will allow for 16 on-site sleep studies per week • Hired a full-time Sleep Medicine physician (July 2005) and a full-time nurse practitioner (December 2005). • Increased capacity to diagnose sleep disorders via use of four home sleep monitors. • Established Telehealth sessions two times monthly with the Ft. Myers CBOC.
Cardiology Service/Cardiac Catheterization.	**Recommendation 10:** The VISN Director, in conjunction with the Medical Center Director, should ensure that the BPVAMC Critical Care Committee oversee quarterly scheduled drills that test the transfer system of critically ill patients from the cardiac catheterization laboratory to a local hospital with which the facility has a cardiac surgery support agreement.	**Resolved**	In April 2005, VHA's National Program Director for Cardiology determined that mock transfers could be waived as long as the facility demonstrated a process of continuous monitoring and formal reporting through the Operative and Invasive Committee. The facility agreed to perform a one-time, baseline mock transfer to Morton Plant Hospital as it had not been utilized as a referral site for over 2 years. The Cardiac Catheterization (Cath) emergent transport occurrences are discussed in the monthly Cath Lab meeting and documented in their minutes. This information is collated and reported quarterly to the Operative and Invasive Committee.

Dermatology Service Procedure Room Did Not Meet Environmental Standards.	**Recommendation 11a – 11b:** The VISN Director should ensure that the Medical Center Director: a. Completes an environmental risk assessment for minor dermatology procedures performed in the portable trailer, and takes action to ensure those procedures are performed in an approved setting. b. Establish a system to identify and track dermatology post-procedure complications.	**Resolved** **Resolved**	a. The VISN completed an environmental risk assessment in October 2004. Although there were not any significant findings, the facility addressed some minor issues. b. Tracking of post-procedure complications began in October 2005 with the arrival of a new Chief of Dermatology; reporting to the appropriate committee began in February 2006. Infection Control staff monitors have not identified any trends or concerns.
Medical Service Did Not Have a Peer Review Process to Monitor Patient Care.	**Recommendation 12:** The VISN Director should ensure that the Medical Center Director takes steps to institute a peer review process in all BPVAMC clinical services.	**Unresolved**	The BPVAMC Peer Review Committee meets regularly to address issues; however, documentation on results and follow-up is inconsistent. Medical center policy states that all clinical services have a peer review process. In two of four services we reviewed, this process was not in place. The COS and Chief, Quality Services, told us they will develop an action plan to ensure compliance with the policy by the individual clinical services. (See page 10 for details.)
Issue 3: Contracting Procedures and Related Issues ***(Issue 3 will be addressed in a separate report.)***			
Issue 4: Deployment of CoreFLS			
Background Investigations of Bearing Point Personnel Were Not Initiated in a Timely Manner.	**Recommendation 15a – 15c:** The Acting Assistant Secretary for Policy, Planning, and Preparedness should: a. Include in the VA Directive and Handbook 0710 currently being amended, a requirement for the Office of Cyber and Information Security to be the approving authority for sensitivity designations for non-VA employees	**Resolved**	a. On May 16, 2005, the Acting Assistant Secretary for Policy, Planning, and Preparedness issued a Memorandum – Issues at VA Medical Center Bay Pines, Florida EDMS 306911. In the memo the Acting Assistant Secretary stated that the Assistant Deputy Assistant Secretary for Cyber and Information Security states that the inclusion of Information Security Officer participation in position risk assessments is sufficient to fulfill the FISMA

	with access to VA systems.		requirements. The memo at paragraph three states that subsequent to issue of VA Directive and Handbook 0710, the Federal Information Processing Standards Publication (FIPS) 201, dated February 25, 2005, has been issued. The FIPS 201 requires that every Federal employee and contractor must undergo a National Agency Check with Written Inquiries as a minimum level background investigation, with a pre-boarding requirement for the completion of a National Agency Check prior to being granted access to Federally controlled government facilities and electronic access to government information systems. (See page 11 for additional finding.)
	b. Initiate the process of including an approval signature block on VA Form 2280 for the Office of Cyber and Information Security approval of the sensitivity designation recommended by the VA organizational unit sponsoring the non-VA employees.	**Resolved**	b. VA Form 2280 has been changed to include a signature block for the Information Security Officer.
	c. Take interim action to ensure that recommendations 15a and 15b are implemented pending the completion of the revised VA Directive and Handbook 0710.	**Resolved**	c. Based on items (a) and (b) above, we consider the recommendation resolved.
The Accuracy of Data Converted to Core FLS Was Not Validated. Employees Did Not Obtain Sufficient Training to Use CoreFLS.	**Recommendation 16a – 16i:** The Assistant Secretary for Management needs to: a. Ensure all facilities have certified the reliability of their existing legacy systems, and accuracy of the data, to ensure conversion problems encountered at BPVAMC will not reoccur at other sites.	**Resolved**	VA decided to terminate the CoreFLS project and revert to the previous systems. All recommendations were overcome by the events of that decision. Once that decision was made, no actions were taken on the OIG recommendations. These decisions were based on the Secretary's guidance. The Financial Services Center in Austin and the Bay Pines Fiscal Officer manually reconciled the transactions from the CoreFLS to FMS at the end of the fiscal year to ensure all obligations and expenditures were accurately recorded and reported.

VA Management Did Not Implement Prior Recommendations. VA Employees Were Not Sufficiently Involved in Testing Procedures. CoreFLS Has Yet to Successfully Interface With All Other VA Medical Center Systems. Fiscal Services Could Not Reconcile Accounts.	b. Strengthen data conversion procedures and tests to provide reasonable assurance that converted data will provide desired results and require certification of implementation. c. Ensure all CoreFLS users are adequately trained to test, operate, and maintain the system. d. Develop and implement a process to address findings and recommendations reported by Access Systems in the September 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Report, the April 2003 CoreFLS Build 1.2 Quality Assurance Independent Verification and Validation Test Results, and the August 2003 CoreFLS Certification and Accreditation Independent Security Test and Evaluation Report. e. Ensure the Independent Verification and Validation process is independently funded and reports to a VA organization outside the Assistant Secretary for Management. f. Segregate the duties of developing tests, executing tests, and determining test results. g. Develop and implement a performance measurement process that will provide VA with an accurate		

	measure of end-to-end response times and delays. h. Develop and implement procedures to test system interfaces and validate results to ensure data moves effectively among all applicable systems. i. Resolve all fiscal reconciliation issues and ensure there are adequate checks and balances between A&MMS acquisition and Fiscal Service obligation process.		
Issue 5: CoreFLS Security Controls			
Duties and Responsibilities of CoreFLS Administrators Were Not Segregated. Managers Did Not Assign Employees Access to CoreFLS Programs Consistent With Their Roles and Responsibilities. CoreFLS Managers Did Not Have an Effective Contingency Plan to Protect Assets and Functionality. Accountability Controls Needed	**Recommendation 17a – 17h:** The Assistant Secretary for Information and Technology should ensure that the CoreFLS Project Director improves CoreFLS security controls by: a. Reducing production access privileges to ensure proper segregation of application developer, system administrator, and security administrator duties. b. Fully developing and testing procedures to ensure roles and responsibilities are assigned to users based on access criteria. c. Developing a contingency plan in accordance with NIST 800-34 and ensuring that testing is conducted on contingency related items to ensure	**Resolved**	VA decided to terminate the CoreFLS project and revert to the previous systems. All recommendations were overcome by the events of that decision. Once that decision was made, no actions were taken on the OIG recommendations. These decisions were based on the Secretary's guidance.

Strengthening. Controls Over Changes to CoreFLS Software Needed Improvement.	continuity of operations in the event of a disruption of service. d. Developing and implementing procedures to monitor and log high-risk user activity and log user access. e. Implementing CCB procedures to help ensure program modifications are properly authorized, tested, and approved. f. Identifying and reviewing all prior changes made by contractors with incompatible duties to ensure the integrity of codes, configurations, and data. g. Documenting the software extensions and other major modifications to track the applicability of these changes to any new releases of the baseline software. h. Ensure software issues are reviewed and comply with all applicable technical requirements.		
Issue 6: Management of Supply, Processing, and Distribution Activities			
Senior Leadership Did Not Adequately Respond to SPD Warnings and Resolve Problems. Senior Leadership Did Not Ensure Suitable	**Recommendation 18a – 18j:** The VISN Director needs to: a. Take appropriate administrative actions against responsible managers for not taking timely actions to preclude surgical work stoppages, inadequate site preparation for conversion to CoreFLS,	**Resolved**	a. Responsible managers were given reprimands, although not for actions outlined in the recommendation. All responsible managers are no longer at VAMC Bay Pines, having been reassigned, relocated, or retired.

Site Preparation for Conversion to CoreFLS.	and procurement disruptions and irregularities.		
	b. Review the appropriateness of the contractor representative's purchases from his own firm, whether actions should be taken to seek reimbursement for any overcharges, and ensure all other purchases made from the blanket purchase order (PO) were appropriate and accounted for.	**Resolved**	b. The OIG Criminal Investigation Division reviewed the contractor's contract and purchases and determined the contract was illegal but not fraudulent. Based on the advice of Regional Counsel, the medical center declined to issue a bill of collection to the contractor.
	c. Take appropriate administrative actions against employees who violated security password and Government Purchase Card procedures.	**Resolved**	c. Medical center management made a decision to remove the employee; before action could be taken, he retired.
	d. Strengthen leadership in SPD by recruiting a proven leader as the Chief, and filling all vacancies.	**Resolved**	d. In May 2004, the medical center recruited a new Chief of SPD with 10 years of experience. The staffing level for SPD has increased by 33 positions with 8 vacancies that are in the process of being filled.
	e. Develop and implement policies and procedures for managing SPD that are proactive, based on VA standards and regulations, and are made available to applicable employees.	**Resolved**	e. A total of 68 policies and procedures were revised or added between June and October 2005. All policies were made available to employees.
	f. Improve security of the SPD stockroom and other inventory areas by restricting access, and obtain surgical case carts that can be adequately secured.	**Resolved**	f. The security of the SPD stockroom and other inventory areas was improved by the installation of an electronic key card system. However, at the time of our review, we found one access door was left open during the hours of 8:00 a.m. to 3:30 p.m. and four vendors had 24/7 access to SPD. Management took immediate action to restrict access to all SPD entrances and terminated access to non-SPD personnel.
	g. Perform a wall-to-wall inventory of SPD and conduct annual inventories of all stock items.	**Resolved**	g. A wall-to-wall inventory was conducted in September 2004, and subsequent cyclic inventories were conducted of all stock items.

	h. Ensure that mandatory inventory management systems are fully used to maintain control over inventory stock and avoid excess purchases.	**Resolved**	h. VAMC is approved to use DynaMed and uses the system to maintain control over the SPD inventory. Bar code technology is used to conduct inventories and distribute supplies.
	i. Ensure that SPD employees are adequately trained in the use of VA-mandated automated inventory management systems.	**Resolved**	i. SPD employees received training in the use of DynaMed during FY 2005.
	j. Ensure that SPD inventory records are updated by removing all nonessential inventory line items from the SPD inventory, moving surgical instrumentation to a separate inventory control point, procuring prosthetic items from the appropriate control point, verifying all vendor file information is complete and accurate, verifying that resource objectives and reorder points are correct for all SPD inventory line items, and correcting quantity discrepancies.	**Resolved**	j. Inactive items have been reduced to about 21 percent of the inventory; this is lower than VA policy that allows facilities to carry inactive items up to 30 percent of the SPD inventory. Surgical instrumentation has been classified as 'Other' in the SPD inventory and carries no dollar value. There are still 1,123 prosthetics items valued at about $45,300 in inventory, but SPD is in the process of moving these items to Prosthetics. DynaMed prevents SPD from inputting vendors that are not in the IFCAP Vendor File. Adjustment to the resource objectives and reorder points will always be necessary but have been brought under control by the cycle inventories. Based on the progress made by SPD in this area, we consider the recommendation resolved.

Appendix B

Review of New Complaints Received by OIG in March 2006
Bay Pines, Florida
Project No. 2006-01217-HI-0305

ISSUES	STATUS	RESOLUTION
Staff must complete pre-requisite testing or treatment before making referrals for some subspecialties.	Confirmed, but practice is acceptable.	Multiple Service Agreements exist which define pre-requisites prior to referral. This practice is in accordance with Advanced Clinic Access (ACA) and facilitates patient care. The pre-requisites appeared appropriate.
Primary Care (PC) nurses only do paperwork; they do not provide patient care.	Not confirmed.	PC nurses are part of the PC team and are performing functions as described in their position descriptions. Clinical functions are appropriate to nursing skills and training.
Laboratory results for arterial blood gases (ABGs) and potassium levels are delayed more than 1 hour during Code Blue resuscitations.	Not confirmed.	For the period May 24–June 24, 2005, the average ABG turnaround times were less than 15 minutes, and January 1–December 31, 2005, the average potassium turnaround times were less than 30 minutes.
Physical therapists do not provide therapy to ICU patients. In some cases, physical therapists instruct patients' family members in therapy techniques.	Confirmed. Management is aware of issue and is taking action.	Due to reduced staffing, physical therapists will evaluate ICU patients at bedside, but will typically instruct the ICU nurses about exercises and range of motion activities. The Critical Care Committee discussed this issue in their March 2006 meeting and will send a letter to the Chief, Physical Medicine & Rehabilitation Service, requesting additional physical therapy support in the ICU.
The ICU accepts overflow patients when general medicine and telemetry beds are full.	Confirmed. Management is aware of issue and is taking action.	The ICU is used when general medical and telemetry beds are full as the hospital does not want to go on diversion (incoming patients transferred to private hospitals). The COS is aware of the issue and chartered a "Patient Flow" team in September 2005 to address choke points in the admission, hospitalization, and discharge processes. The team made multiple recommendations, including increasing the number of general medical and telemetry beds. Follow-up of the recommendations has been assigned to Utilization Review.
ACA allows patients to "fall through the cracks."	Not confirmed.	ACA is mandatory and while some providers don't like the restrictions, BPHCS has systematically rolled out ACA and taken steps to minimize disruptions. BPHCS uses a tickler system to contact veterans who don't call for follow-up appointments, and will be initiating a call-center in May 2006 to manage call-ins and call-backs.
Patients do not receive conscious sedation for bronchoscopies.	Confirmed, but practice is acceptable.	Patients do not receive conscious sedation due to staffing requirements; however, patients do receive pre-procedure medication. We did not identify any patient complaints of pain during bronchoscopies.

Appendix B

Pain Clinic does not see inpatients; rather, patients are referred to Neurology.	Confirmed, but practice is acceptable.	Per policy, Pain Clinic does not typically treat inpatients. Inpatients with pain are supposed to be treated by their respective hospitalists. Some of the hospitalists still consult Neurology.
Orthopedic Clinic does not see patients with neck or back pain.	Confirmed, but practice is acceptable.	The Primary Care/Medical Service-Orthopedics Service Agreement allows for exceptions after Service Chief review of the case. Other mechanisms for treatment of chronic pain exist through Neurology, Pain Clinic, and Primary Care.
PC staff need panic buttons.	Not confirmed.	BPHCS Police conducted a review and found panic buttons were not warranted in the areas requested. Other emergency distress systems are in place.
Rheumatology will not see fibromyalgia patients.	Confirmed, but the practice is acceptable.	Rheumatology will consult and establish the diagnosis of fibromyalgia; however, rheumatology does not follow fibromyalgia patients. The American College of Rheumatology takes the position that fibromyalgia can generally be treated by PC providers.
Communication between inpatient and outpatient providers does not promote continuity of care; discharge summaries are not complete before patients return for PC appointments.	Not confirmed.	Review of 20 randomly selected medical records of patients discharged between January 1–March 15, 2006, reflected that, in all 20 cases, discharge summaries were complete before the next PC appointment. In one case, the hospitalist forwarded the discharge summary to the patient's outpatient provider for 'receipt acknowledged' signature.

Appendix C

VISN 8 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 25, 2006

From: VISN 8 Director (10N8)

Subject: **Follow-Up Evaluation of Clinical and Administrative Issues, Bay Pines Health Care System, Bay Pines, FL**

To: Office of Inspector General

Thank you for the opportunity to review the draft report of the Follow-Up Evaluation of Clinical and Administrative Issues, Bay Pines Health Care System, Bay Pines, FL.

The facility management has been dedicated to making improvements for both patients and employees and we appreciate that some of their accomplishments have been recognized.

The VISN concurs with the report, the recommendations and the actions that are being implemented to make improvements.

Please contact Karen Maudlin at (727) 319-1063 if you have any further questions.

Sincerely,

(*original signed by:)*
George H. Gray, Jr

Network Director

Appendix D

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 23, 2006

From: Health Care System Director (516/00)

Subject: **Follow-Up Evaluation of Clinical and Administrative Issues, Bay Pines Health Care System, Bay Pines, FL**

To: Office of Inspector General

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1a. The VISN Director should ensure that the BPHCS Director takes actions to ensure that Radiology interprets mammograms within 48 hours, and implements a system to assure that VA mammography reports are appropriately addended when comparison films are received.

Concur Target Completion Date: July, 2006

Immediate actions have been taken to ensure interpretation of mammograms within 48 hours. A Radiologist is assigned to read mammography exams on a daily basis. A monitor has been implemented to ensure the timely readings of mammography exams. A performance goal of 90% of exams read within 48 hours has been set. Compliance will be reported monthly to the Chief of Staff. New digital mammography equipment has been ordered and should be functional by July. This will increase the number of radiologists who will have access to read the mammograms.

Recommended Improvement Action(s) 1b. The VISN Director should ensure that the BPHCS Director takes actions to ensure that Radiology periodically reviews STAT and urgent requests ordered for future dates and determines whether any trends can be identified

by ordering physician, clinic location, exam modality, or other factors, and take corrective action, as necessary.

Concur Target Completion Date: Completed

The Medical Center has implemented a monitor to ensure STAT and Urgent requests are appropriately ordered. A sample of imaging exams from the various imaging modalities will be reviewed for appropriateness using the report methodology provided by the OIG. If monitoring demonstrates non-compliance, training will be provided to ordering practitioner/clinical staff to ensure STAT and Urgent requests are ordered appropriately. The process for entering the request is also under review to determine if the request is appropriately classified at the time of order by the provider or if the request is entered incorrectly at the clerical entry point. The monthly report will be submitted to the Chief of Staff.

Recommended Improvement Action(s) 1c. The VISN Director should ensure that the BPHCS Director takes actions to ensure that Radiology monitors and evaluates productivity to ensure that assets are appropriately managed.

Concur Target Completion Date: Completed

Ongoing monitoring of provider productivity is conducted by the Radiology Service with an RVU report presented to the Chief of Staff every week. The target goal of 6,000 RVU's will be utilized as the performance measurement for all full time physicians. The target goal of 3,000 RVU's will be utilized as the performance measurement for Service Chiefs. Performance will be measured by utilizing VA Central Office criteria which states 90% of all imaging exams will be interpreted within 48 hours or less. This will be reported monthly via the performance indicator report.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the BPHCS Director requires clinical services to comply with the facility's peer review policy and that Quality Systems oversight is adequate to evaluate the effectiveness of the required peer review process.

Concur Target Completion Date: Completed

The clinical service-level peer review process outlined in medical center policy Peer Review for Quality Management dated May, 2005

was outdated and did not reflect changes in JCAHO standards regarding the focused review process. Service-level peer review is not required by VHA Directive 2004-054, Peer Review for Quality Management, or by JCAHO standards. Including service-level peer review in the local policy created confusion as to what information was protected from use in the reprivileging process. For these reasons, the Healthcare System policy, Peer Review for Quality Management, was reissued in May, 2006 to remove the requirement for service level peer review. Clinical services are conducting quality of care reviews to collect provider-specific information and/or to identify and improve processes within their scope of responsibility. The current organization-wide peer review process has been reviewed by the VISN 8 Chief Medical Officer (CMO) and determined to be in compliance with the VHA Directive 2004-054. The new Patient Safety Managers in Quality Systems have received training about peer review and staffing is adequate to oversee the process.

Recommended Improvement Action(s) 3. The VISN Director, BPHCS Director, and VA Office of Security and Law Enforcement should ensure that the background clearance process is completed for employees of the vendor supporting DynaMed.

Concur Target Completion Date: June 2006

Employees, under the contract with Information Control (vendor/contractor), have worked to support DynaMed for at least 3 years. They were employed under the failed CoreFLS operational test contract. They are presently employed under both a Central Office maintenance contract and a local BPHCS contract to support the IFCAP-DynaMed Interface software. Employees of Information Control are tasked to support the DynaMed software used to manage the facility's inventory and supply processes. Bay Pines entered into a local contract with Information Control in June 2005 to provide necessary maintenance on the above interface. BPHCS did not conduct background checks on these contractors at that time as they were already working under a Central Office contract and the assumption was made that background checks had already been conducted. BPHCS verified with the contractor, Information Control, to see if their staff had previously provided information for the background checks and they responded affirmatively. However, we were unsuccessful in verifying with VA Central Office or other entities that background checks had been conducted.

To correct this oversight, BPHCS has initiated the process to conduct background checks on all Information Control staff who are responsible for supporting the local contract. New applications for the background checks will be completed in June 2006 and submitted to the Office of Security and Law Enforcement in Arkansas for their processing.

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Appendix F

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