Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Syracuse VA Medical Center Syracuse, New York

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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 March 6–10, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Syracuse VA Medical Center, Syracuse, New York. The purpose of the review was to evaluate selected 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 to 139 employees. The medical center is under the jurisdiction of Veterans Integrated Services Network (VISN) 2.

Results of Review

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

- Accounts Receivable
- All Employee Survey
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Quality Management
- Unliquidated Obligations

We identified the following organizational strength:

- The medical center efficiently managed and utilized staff radiologists resulting in a high Relative Value Unit (RVU) productivity level in fiscal year (FY) 2005.

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

- Strengthen controls to improve oversight of the contracting activity and contract administration, and avoid conflicts of interest.
- Improve the cost efficiency of outsourced radiology services.
- Strengthen controls to account for and safeguard sensitive equipment.
- Strengthen controls for information technology (IT) security.
- Verify that non-VA facilities providing mammography services to VA patients are appropriately certified.

This report was prepared under the direction of Mr. Thomas L. Cargill, Jr., Director, and Mr. Philip D. McDonald, Audit Manager, Bedford Audit Operations Division.

Acting VISN 2 and Medical Center Director Comments

The Acting VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 19-28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at eight community-based outpatient clinics (CBOCs) located in Massena, Carthage, Cortland/Ithaca, Auburn, Rome, Watertown, Oswego, and Binghamton, New York. The medical center serves a veteran population of about 190,000 in central New York.

Programs. The medical center provides comprehensive health care through primary, tertiary, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The medical center has 106 hospital beds as well as a 48-bed transitional care unit.

Affiliations and Research. The medical center is academically affiliated with the State University of New York (SUNY) Upstate Medical University. It is also affiliated with SUNY programs in health sciences, including: dentistry, nursing, pharmacy, physical and occupational therapy, psychiatry, psychology, social work, and health care administration. The medical center research program had 95 active protocols with a FY 2005 budget of approximately $2.5 million.

Resources. The medical center's FY 2005 medical care budget was $158.2 million, a 6.9 percent increase over FY 2004 funding of $148 million. FY 2005 staffing was 1,096 full-time equivalent employees (FTE), including 74 physician FTE and 346 nursing FTE.

Workload. In FY 2005, the medical center treated 39,684 unique patients, a 3.5 percent increase from FY 2004. The FY 2005 inpatient care workload totaled 3,404 inpatients treated and 374,820 outpatient visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial and administrative records. The review covered the following 11 activities:

- Accounts Receivable
- All Employee Survey
- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Equipment Accountability
- Information Technology Security
- Quality Management
- Radiology Services
- Service Contracts
- Unliquidated Obligations

The review covered medical center operations for FY 2004 to FY 2006 through March 2, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations of our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Health Care Network Upstate New York at Syracuse,* Report No. 00-02023-36, March 26, 2001).

As part of the review, we interviewed 30 patients. The surveys indicated high levels of patient satisfaction and the results were shared with medical center managers.

We also presented 2 fraud and integrity awareness briefings for 139 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (see pages 4–15). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Organizational Strength

Staff Radiologist Productivity Exceeded Internal Benchmarks. The medical center efficiently managed and utilized staff radiologists resulting in a high RVU productivity level in FY 2005. The medical center began using RVUs as a measurement tool when it became available to management in FY 2005. The medical center utilizes this tool to develop RVU reports that show the department's workload and the productivity levels of contract and staff radiologists. The average productivity level of the medical center's VA staff radiologists in FY 2005 was 5,943 RVUs per clinical FTE, which exceeded the benchmark of 5,000 RVUs per clinical FTE we used to assess VA radiologists' productivity. Medical center management also developed RVU reports that identified the total workload and productivity of VISN 2 facilities. They are in the process of developing a more detailed report that will incorporate each facility's staff and contract radiologists' resources. This report will help enable the VISN to more effectively manage and utilize radiologist resources.

Opportunities for Improvement

Service Contracts — Oversight of the Contracting Activity and Contract Administration Needed To Be Improved

Conditions Needing Improvement. Medical center management 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), VA policy, and Veterans Health Administration (VHA) policy. To evaluate the effectiveness of the contracting activity, we reviewed 9 contracts valued at $6 million from a universe of 54 service contracts valued at $29 million. We identified the following issues that required 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, VA policy, and VHA policy. The HCA did not ensure required contract reviews were conducted for any of the 9 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, VA policy, and VHA policy. Tangible benefits were achievable had the HCA conducted contract file reviews.

- Cardiology Consultative Services. Contract file reviews would have disclosed that the medical center had two contracts with the affiliate for cardiology consultative services. The two contracts were valued at $96,000 and $278,000, and the contract periods were from August 2004–July 2005.

  A contract was renewed with the affiliate on August 1, 2004, to provide physician consultative services in the following disciplines: Cardiology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Pulmonary, Geriatrics, and Rheumatology. The cardiology consultative services were to be billed at a rate of $75 per visit. This was the fourth renewal of this contract.

  A second contract was awarded to the affiliate 5 days later on August 6, 2004, to provide cardiology consultative services and other cardiology related services. Other cardiology services included electrocardiogram interpretations, physician services for implantation of cardiac devices, and supervision of a cardiology fellows' clinic at the medical center. The cardiology consultative services were to be billed at a rate of $500 per day. This contract was intended to be a temporary contract because the medical center was losing a cardiologist. The contracting officer for this contract was

unaware that cardiology consultative services were being provided by the affiliate under a separate contract.

A review of both contracts and related supporting documentation showed that the medical center should have been billed by the affiliate under the terms of the initial contract at the rate of $75 per visit rather than $500 per day. A visit, as used in the contract, is defined as any time a cardiologist is called to the medical center for consultative services identified in the Fee Schedule at rate of $75 per visit on a per patient basis. The affiliate billed the medical center for cardiology services at the rate of $500 per day for 266 days totaling $133,000 during the period August 11, 2004, to July 17, 2005. The medical center should have been billed at the $75 per visit rate for 296 visits totaling $22,200. As a result, the medical center overpaid the affiliate for cardiology services in the amount of $110,800 ($133,000 – $22,200). Medical center management agreed with the overpayment amount and will initiate a bill of collection to the affiliate.

In addition, a cardiologist was providing cardiology consultative services as a VA employee and as a contracted cardiologist. The affiliate was billing the medical center contract hours for the cardiologist, when the part-time cardiologist (.2 FTE) was performing his duties as a medical center employee, resulting in an overpayment of $9,250 ($500 x 18.5 days). The medical center initiated a bill of collection to recover the overpayments from the affiliate.

CO Performance. COs did not take necessary actions to prevent apparent conflicts of interest, maintain complete files containing records of required preaward and postaward administrative actions, or ensure COTRs received VA mandated training before assuming responsibility for monitoring contractor performance.

- Apparent Conflicts of Interest. We determined that three VA physicians had apparent conflicts of interest involving a contract with an affiliated practice group. The medical center had a $465,000 contract to provide radiation therapy services from October 1, 2002–September 30, 2005. The apparent conflicts of interest occurred because these VA employees, who held unpaid faculty appointments at the facility's affiliated medical school, participated as members of the medical center negotiation team for this contract. Generally, if a VA employee has a faculty appointment and receives any compensation, or is under the direction of the school, the VA employee has an imputed financial interest in the VA contract with the school's practice group. 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 contract under discussion, the employees participated in the contract 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; and that the

physician is required to sign VA Form 10-21009, acknowledging receipt of the handbook and agreeing to abide by the guidance contained in the handbook. Of the 114 VAMC physicians required to sign VA Form 10-21009, only 10 physicians had done so. The 3 physicians under discussion were not among the 10 signatories.

- Required Preaward Administrative Actions. COs did not conduct required preaward administrative actions, including pricing analyses for two contracts valued at about $370,000 and market research for three contracts valued at $3.7 million. COs did not research the Excluded Parties Listing System database for five contracts valued at $2.26 million to determine whether the prospective contractors were excluded from Federal contracts. Price negotiation memoranda were not prepared for four contracts valued at $4 million. COTR appointment letters were not issued for three contracts valued at $1 million.

- Required Postaward Administrative Actions. COs did not conduct required postaward administrative actions including the initiation of background investigations (BIs) of contract personnel with access to VA computer systems for seven contracts valued at $4.6 million. Additionally, they did not prepare written justifications before exercising option years for three contracts valued at $960,000.

- COTR Training. COs did not ensure nine COTRs for nine contracts valued at $6 million had received training before assuming their responsibilities for monitoring contractor performance. The training explains COTR duties, responsibilities, limited authority, and prohibited actions.

Recommendation 1. We recommended that the Acting VISN Director ensure that the Medical Center Director takes actions to:

a. Conduct contract file reviews to ensure compliance with the FAR, the VAAR, VA policy, and VHA policy.
b. Recover overpayments from the affiliate for cardiology services and establish controls to prevent future duplicate service contracts.
c. Strengthen controls to prevent apparent conflicts of interest, and if required, seek and abide by VA Regional Counsel's opinion.
d. Correct the required preaward and postaward administrative deficiencies and strengthen controls and oversight to prevent deficiencies on future contracts.
e. Ensure COTRs receive training as specified by VA policy.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations and reported that the HCA will ensure that contract file reviews are conducted to comply with the FAR, the VAAR, VA policy, and VHA policy. The $9,250 overpayment has been recovered and a bill of collection for $110,800 has been prepared and will be delivered to the affiliate. Internal controls will be implemented to prevent future duplication of services. A conflict of interest questionnaire will be used to prevent

conflicts of interest and will be used as a basis for seeking VA Regional Counsel's opinions. A checklist and quarterly audits will be used to correct and prevent contract administration deficiencies. COTRs will receive training as specified by VA policy. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

Radiology Services – The Cost Efficiency of Outsourced Services Needed To Be Improved

Conditions Needing Improvement. Improving the cost efficiency of outsourced radiologist services will allow the medical center to reduce radiologist contract costs by as much as $81,996 annually. The medical center's FY 2005 average outsourcing cost per RVU was high because of high contracting costs for subspecialty interventional radiology services. The high average cost per RVU for interventional services can be reduced by acquiring services at a lower price. Additionally, the medical center will also be able to reduce the amount of outsourced interventional radiology services needed since the Chief, Radiology Service has recently completed training that will enable him to provide interventional services.

Cost per RVU. The cost per RVU measures the cost efficiency of radiologist services by dividing the total cost of services by the total amount of RVUs produced. 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 cost per RVU
- Private Sector salary: $345,000 / 7,100 RVUs = $49.00 cost per RVU

The academic and private sector's cost per RVU figures above are for general radiology services and do not account for any additional costs that may be associated with contracting radiologist services.

FY 2005 Outsourcing Costs. The medical center outsourced radiologist services through a contract vendor and fee basis radiologists in FY 2005. The following table shows the workload, costs, and cost per RVU for the contract vendor and fee basis radiologists in FY 2005.

Table 1

Source	Total RVUs	Total Costs	Cost per RVU
Contract Vendor	2,182	$224,781	$103
Fee Basis	4,339	281,080	65
FY 2005 Outsourced Totals	6,521	$505,861	$78

The combined outsourcing cost per RVU was $78 in FY 2005, which is $29 above the cost per RVU for the academic and private sectors and $31 above the medical center's $47 cost per RVU for VA staff radiologists. The contract vendor, who had a cost per RVU of $103, provided interventional radiology services. The fee basis radiologists, who had a cost per RVU of $65, performed general radiology examinations.

The high cost per RVU for the contract vendor can be attributed to the high hourly cost of $325 paid for interventional radiology services. The medical center's Radiology Service Chief was absent for a year (January 2004 through December 2004) and completed a fellowship that enables him to perform interventional procedures. The medical center may have the opportunity to negotiate lower prices for radiologist services when the current contract expires in June 2006. With the added ability for in-house staff to perform interventional services, the medical center may be able to adjust its contracting needs more towards general radiology that will help lower the outsourcing cost per RVU. If the average cost per RVU of the medical center's FY 2005 total outsourced workload of 6,521 RVUs can be reduced from $78 per RVU, to the FY 2005 fee basis cost per RVU of $65, the medical center's total cost would be reduced from $505,861 to $423,865 (6,521 RVUs x $65 per RVU). Improving the cost efficiency of outsourced radiology services would subsequently save the medical center an estimated $81,996 annually.

Recommendation 2. We recommended that the Acting VISN Director ensure the Medical Center Director reviews the amount of contract interventional services needed and takes steps to improve the cost efficiency of outsourced radiologist services.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation and reported that action will be taken to determine the amount of contract interventional services needed. To improve the cost efficiency of outsourced radiology services, the current contract will be terminated and a Request for Proposal for a competitive bid will be issued. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

Equipment Accountability – Controls to Account For and Safeguard Sensitive Equipment Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to improve procedures to ensure that sensitive equipment was properly accounted for and safeguarded. Sensitive equipment is defined as property, regardless of acquisition cost, that by its nature is subject to theft, loss, conversion to personal use, or for some other reason must be subjected to more stringent controls than other property. During our review, we performed testing to determine whether sensitive IT equipment was being properly accounted for, safeguarded, disposed of, and recorded in the Automated Engineering Management System/Medical Equipment Reporting System

(AEMS/MERS), VA's property database. We found that Acquisition and Materiel Management Service (A&MMS) did not have controls in place to: locate and account for computer equipment listed in the current property database; ensure that computer equipment data recorded in AEMS/MERS was complete and accurate; track computer equipment classified as "out of service"; document the proper disposal of computer equipment and the sensitive data stored on it; and maintain a Report of Survey Program for all lost, stolen, damaged, or destroyed computer equipment. During our review, we also found that equipment inventory procedures to account for all nonexpendable and leased property needed to be improved. The following are issues identified during our review that required management attention.

Sensitive IT Equipment Accountability. We selected a random sample of 78 sensitive IT equipment items listed in the property database, for physical verification. We also used these items to determine if data listed in AEMS/MERS was accurate and complete. We identified the following accountability discrepancies:

- A&MMS and Information Resource Management (IRM) staff could not locate 53 (68 percent) of the 78 items (total estimated acquisition value = $66,982[1], total estimated current value = $22,483). These unaccounted for items included 29 computers, 10 monitors, 11 printers, and 3 bar code scanners.

We were able to physically verify the remaining 25 items, but found the following discrepancies:

- Twenty items had incorrect locations listed in AEMS/MERS.
- Two items had incorrect serial numbers listed.
- Two items had incorrect models listed.
- One item had an illegible bar code label due to wear and tear.

Based on the results of this statistical sample, we estimate 3,582 sensitive IT equipment items, with total acquisition value of $4,577,040, could be missing.

In addition to the above sample, we selected 10 computers (total acquisition cost = $34,478) that were acquired in 1997 and 1998, for physical verification. A&MMS and IRM staff could not physically account for any of the 10 computers. The IRM Operations Manager stated that because the computers were older, they were possibly turned in, and proper documentation was never prepared.

We also selected 20 computers (total estimated acquisition cost = $28,726[2]) that were acquired between October 2004 and January 2006, for physical verification. A&MMS

[1] Acquisition value is estimated because for 13 of the 53 items, where no acquisition cost was listed, we used the average acquisition cost for all sensitive IT equipment, which was $1,283.
[2] Acquisition costs are estimated because for 10 of the 20 items, where no acquisition cost was listed, we used the average acquisition cost for all sensitive IT equipment, which was $1,283.

and IRM staff could not physically account for 2 (10 percent) of the 20 computers. They were a Micron PC computer that was purchased in November 2004 for $1,174 and a Dell computer that was purchased in October 2004 for $1,005. We were able to account for the remaining 18 computers, but found the following discrepancies:

- Seven items had the wrong locations listed in AEMS/MERS.
- Seven items had the wrong serial numbers listed.
- Two items did not have bar code labels affixed to them.

"Out of Service" Equipment. A&MMS staff provided a report of all equipment listed in the property database as "out of service." The list contained 438 items, with an estimated total acquisition value of $2,875,702,[3] of which 50 (11 percent) were sensitive IT equipment. To assess accountability controls over sensitive IT equipment categorized as "out of service," we selected 10 computers (total acquisition cost = $26,808) from the list of 50 items, for physical verification. A&MMS and IRM staff could not account for any of the 10 computers.

A&MMS staff must attempt to account for all sensitive "out of service" equipment. Items that cannot be located should be listed on a "Report of Survey" ("ROS"), VA Form 1217 in order to remove them from the property database.

Disposed Equipment. We selected 15 computers (total acquisition value = $27,950) from a list of 284 items with a total acquisition value of $881,239, which have been turned in since October 1, 2004. We requested A&MMS staff provide us with documentation verifying that each of the 15 items was disposed of properly and in accordance with VA policy. They could not provide sufficient documentation to support the disposal of any of the 15 items. We could not determine if these computers or the sensitive data stored on the hard drives were properly disposed of and safeguarded. Electronic inventory records for 8 of the 15 computers showed the items classified as "turned in," while the remaining 7 were listed as "in use." The Chief of A&MMS stated that an electronic turn in had been established for these 7 items; however, they were never properly removed from the property database.

A&MMS staff must complete equipment disposal transactions in accordance with VA policy to include properly removing the items from AEMS/MERS, and maintaining documentation that verifies the propriety of each disposal transaction.

"ROS" Forms. VA policy requires that a "ROS" form be completed for equipment that is lost, stolen, damaged, or destroyed. A Board of Survey should document findings, fix responsibility, and record pecuniary liability (if any). The "ROS" form will be the official document used to adjust the property database, and should be maintained by

[3] Acquisition value is estimated because 68 of the 438 items did not have acquisition values listed in AEMS/MERS.

A&MMS. We requested a copy of all "ROS" that have been completed within the past 2 years. The Chief of A&MMS stated that no "ROS" have been completed in the past 5 years.

We requested from Police Service a copy of all "Uniform Offense Reports" from the past year for any computer equipment that had been reported stolen. We were provided six reports listing a total of eight items (total acquisition value = $7,695) that had been reported stolen including, three laptop computers, two desktop computers, one monitor, and two wireless cards.

The Chief of A&MMS stated that Police Service has never provided him a copy of these reports and "ROS" were not completed. Police Service should work with A&MMS staff to complete a "ROS" when they receive a report involving the reported theft of Government property.

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

- Prior to FY 2006, sensitive equipment with an acquisition value of less than $5,000, which includes most computer equipment, was not listed on an EIL. Therefore, sensitive equipment was not accounted for during physical inventories. Local policy has been changed to require responsible officials to create a list of all sensitive equipment assigned to them, and return it to A&MMS along with the results of their EIL inventories. However, the EIL listing that is provided to each responsible official for physical verification currently does not include sensitive equipment with an acquisition value of less than $5,000. A&MMS staff should complete a 100 percent wall-to-wall inventory to identify all sensitive equipment, regardless of cost. This sensitive equipment must be listed in AEMS/MERS and included on an applicable EIL, to be physically verified during the annual EIL inventories.

- VA policy requires that all property leased for more than 90 days will be entered into AEMS/MERS and listed on an EIL. During our review, A&MMS staff provided us a list of 45 leased vehicles, none of which were listed on an EIL. IRM staff also provided us with a list of 640 leased items, including computers, printers, monitors, and other computer-related equipment. These 640 items were entered into AEMS/MERS; however, they were not listed on EILs. These items were not accounted for as part of the annual physical inventories. A&MMS staff needs to make sure that all equipment leased for more than 90 days is listed on an applicable EIL.

- We also reviewed a sample of 14 EIL folders from FYs 2004, 2005, and 2006 to determine what documentation was maintained summarizing the results of the completed inventories. Of the 14 EIL folders, 4 folders contained sufficient documentation of completed inventories. However, the following deficiencies were identified:
    - Five folders contained evidence that inventories were completed but were not sufficiently documented.
    - Five folders did not contain documentation that inventories were completed.

  A&MMS staff must require responsible officials to completely document results of their physical inventories.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that:

a. A 100 percent wall-to-wall inventory is completed to identify all sensitive equipment on hand.
b. Responsible officials document and notify A&MMS of all blank, incorrect, and incomplete data fields for the equipment listed on their EILs, for correction in AEMS/MERS during annual EIL inventories.
c. A&MMS staff reviews the "out of service" equipment listing to ensure that it is accurate.
d. A&MMS staff requires and maintains complete documentation for disposed equipment.
e. "ROS" are completed for all equipment that is lost, stolen, damaged, or destroyed.
f. Sensitive equipment, regardless of acquisition cost, is listed on EILs and physically verified during annual EIL inventories.
g. Property leased for more than 90 days is listed on EILs and physically verified during annual EIL inventories.
h. Responsible officials physically verify all equipment assigned to them during annual EIL inventories.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations and reported that the Chief of A&MMS will ensure that a wall-to-wall inventory of sensitive equipment is performed; Careline Managers will work with A&MMS to correct blank, incorrect, and incomplete data fields listed in the EILs for correction in AEMS/MERS; A&MMS staff will review the "out of service" equipment listing and make corrections; A&MMS will develop a standardized format to document disposed equipment; procedures will be implemented to ensure that a "ROS" is completed for all equipment that is lost, stolen, damaged or destroyed; action will be taken to ensure that sensitive equipment, regardless of acquisition cost, is listed on EILs and physically verified during annual EIL inventories; the Careline Managers will work with A&MMS to ensure that property leased for more than 90 days is listed on EILs and

physically verified during annual EIL inventories; Careline Managers and the designated Responsible Officials will physically verify items on their EILs and A&MMS personnel will verify the annual inventories. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to strengthen 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. Our review found the medical center had implemented port security, which lowered the risk of unauthorized access to the network, and that security and antivirus updates were being done on a regular basis. The following issues required management attention.

Hard Drive Sanitation. VA policy requires that 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 identified as turned in within the past 15 months, and requested documentation showing that the hard drives had been properly sanitized or destroyed. Requested documentation could not be provided for 6 of the 15 computers. Without proper documentation, we could not be assured that these hard drives had been properly sanitized or destroyed prior to disposal.

Physical Security. VA policy requires that proper safeguards must be in place to protect each facility's AIS resources, including the computer room, telephone switch room, and all communication closets, from unauthorized access or destruction. While access to the computer room, telephone switch room, and communication closets appeared to be limited to only those with legitimate needs for access, we found that two communication closets located at the medical center had windows on the entry door. Both communication closets were locked; however, the windows allowed one to view the contents of these rooms. Corrective actions were taken while we were onsite to block these windows. At the Rome CBOC, we also found a communication closet with a window on the entry door. At the medical center, motion detection alarm systems were not installed in either the telephone switch room or the computer room. VA policy requires this device be installed where AIS are located.

Security Awareness Training. VHA policy requires that all facilities establish AIS security awareness training programs to ensure all individuals who manage, operate, program, maintain, or use AIS are trained prior to being granted access to AIS resources. All individuals with access to AIS resources must also be provided with refresher training at least annually. The Information Security Officer (ISO) is responsible for overseeing the security training program. A review of the facility's training program found annual

refresher training was completed by only 953 (84 percent) of 1,131 permanent employees and 1,043 (92 percent) of 1,131 individuals who had access to AIS resources during FY 2005. The ISO needs to work with each service to make sure all individuals with access to AIS resources complete the required annual security awareness training.

Background Investigations. VA policy requires full background investigations (BIs) for all personnel who have access to sensitive data and information. We selected seven employees who held positions requiring BIs, including the VISN and medical center ISOs and IRM personnel. As of March 2, 2006, proper BIs had been initiated for six of seven employees. However, only two BIs had been completed, while four were pending. These BIs had been pending for 11–13 months. In the remaining case, a minimum BI, rather than a full BI, had been requested. Due to the high-level access this individual has, a full BI needs to be requested for this employee. Human Resources personnel need to follow up with the Office of Personnel Management on the four pending cases to make sure they are completed.

Automatic Session Timeout. The automatic session timeout feature was not activated on all medical center workstations. Microsoft Windows operating systems have a built-in security feature that, when activated, will timeout after a specific period of time when a workstation has been left idle. The user is then required to reenter their password before they can resume using their workstation. This feature improves protection over sensitive information in the event an employee walks away from their workstation leaving sensitive information displayed on the monitor. VHA requires that an automatic session timeout feature be implemented on all workstations. The VISN ISO informed us that they are currently in the process of addressing this requirement throughout the VISN.

Recommendation 4. We recommended that the Acting VISN Director ensure the Medical Center Director takes action to:

a. Maintain documentation to track and document the status of computer hard drives through final sanitation and disposition.
b. Improve physical security of the communication closet door at the Rome CBOC.
c. Install motion detection alarm systems where noted.
d. Ensure all individuals with access to AIS resources complete required annual security awareness training.
e. Initiate a full BI on the identified IRM employee and follow up on the four pending BIs.
f. Implement an automatic session timeout feature on all medical center workstations.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations and reported that documentation is now maintained to track the status of computer hard drives until destruction. IT equipment from the communication closet at the Rome CBOC has been relocated to a secure room. Motion detection equipment has been approved for FY 2007. Annual security awareness training will be required of all

employees having computer access. A BI will be initiated on the identified IRM employee and follow up will occur on the four pending BIs. The VISN is in the process of phasing in a screensaver approved by the VA Office of Cyber and Information Security. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management – Verification of Mammography Certification Needed To Be Obtained

Condition Needing Improvement. Medical center managers needed to verify that non-VA facilities providing mammography services to VA patients were appropriately certified. VA regulations require VA medical facilities referring patients to non-VA mammography sites to have verification that these sites maintain current Mammography Quality Standards Act (MQSA) certifications issued by the Food and Drug Administration (FDA) or by a FDA approved state (some states may qualify as non-VA mammography certifiers if approved by the FDA). VA regulations further state that retention of FDA certificates by the referring VA facility is assurance that non-VA facilities are appropriately accredited and certified. The medical center referred patients for mammography examinations to eight non-VA facilities. Medical center managers initially could not provide documentation that those eight facilities held current FDA certifications. However, managers contacted the eight facilities and were able to provide the documentation prior to end of the CAP review. Clinical managers told us that they were unaware of the requirement to maintain this documentation at the medical center.

Recommendation 5. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that verification of current certification of non-VA facilities providing mammography services to VA patients is obtained and retained at the medical center.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations and verified that all facilities providing mammography services to VA patients are currently certified to provide mammography services. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

Other Observations

Diabetes and Atypical Antipsychotic Medications – Screening Processes Were Appropriate and Processes Were Implemented To Improve Diabetes Management

The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic

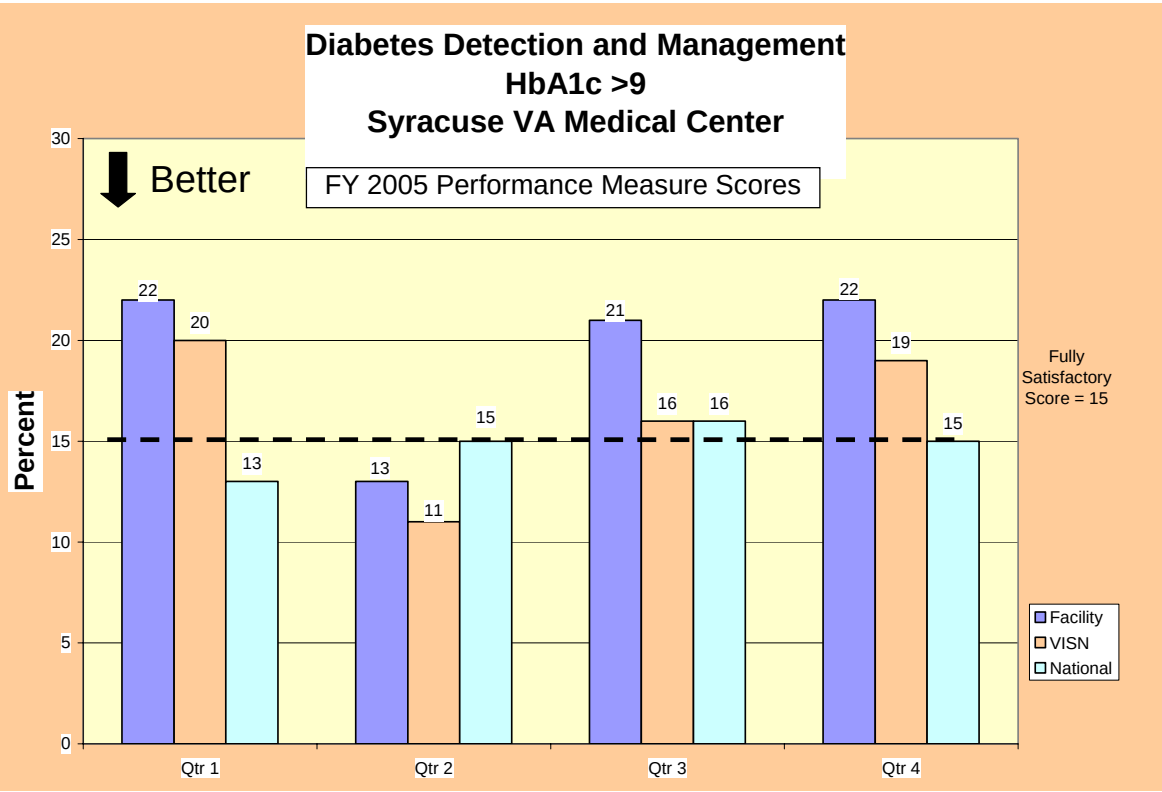
medications (medications that cause fewer neurological side effects, but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that diabetic patients' hemoglobin A1c (HbA1c) levels, which reflect the average blood glucose level over time, be obtained at least annually and be maintained at less than 9 percent to avoid symptoms of hyperglycemia (high blood sugar); that blood pressures (B/P) be maintained at less than, or equal to, 140/90 millimeters of mercury (mmHg); and that low-density lipoprotein cholesterol (LDL-C) levels be maintained at less than 120 milligrams per deciliter (mg/dL).

VHA clinical practice guidelines for the screening of patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) levels be obtained every 1 to 3 years.

We reviewed a random sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days. Three patients had diabetes. The review showed that one of the three patients did not have HbA1c or LDL-C levels obtained since December 2003. At that time, the levels showed that the patient's blood glucose and cholesterol were in control. We found that the patient did not keep a scheduled primary care appointment in 2004 and had not rescheduled the appointment. However, the patient did keep mental health appointments, and mental health clinicians agreed that they needed to ensure that the patient received appropriate monitoring.

We reviewed the medical center's HbA1c performance measure scores for FY 2005 and found that fully satisfactory scores (no more than 15 percent of the patients tested have a HbA1c level of 9 percent or above) were not obtained for 3 quarters of 2005 (see graph on the following page). However, clinical managers identified this issue prior to the CAP review and provided us with an acceptable action plan, which had been recently implemented.



The 10 remaining patients who did not have diabetes were appropriately screened, and 9 were appropriately counseled about diabetes prevention. The remaining patient did not have documented diabetes prevention counseling; however, clinicians used an acceptable FBG level of 115 mg/dL as the upper parameter of normal. This patient's FBG was 111 mg/dL. See Table 2 below for a complete summary of the results of the review.

Table 2

Diabetic patient with HbA1c > 9 percent or not done	Diabetic patients with B/P < 140/90 mm/Hg	Diabetic patients with LDL-C < 120 mg/dL	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
33 percent (1/3)	100 percent (3/3)	33 percent (1/3)	100 percent (10/10)	90 percent (9/10)

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 medical center met the requirements of the ECF Performance Plan. The medical center's AES coordinator distributed survey results through electronic mail and service meetings, and medical center managers conducted town hall meetings. Managers developed measurable improvement plans based on an analysis of survey results. The improvement efforts resulted in an employee Health and Wellness program. Also, managers incorporated an additional employee survey tool to gather information about employees' satisfaction related to their work areas.

Appendix A

VISN 2 Acting Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2006

From: Acting VISN 2 Director

Subject: **Combined Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York**

To: Office of Inspector General (50)

1. Attached is the response to the Syracuse VA Medical Center Combined Assessment Program Review conducted at the facility on March 6-10, 2006.

2. If you have any questions or need additional information, please contact James Cody, Medical Center Director VAMC Syracuse by calling (315) 425-4895.

(original signed by:)

Michael S. Finegan

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2006

From: Medical Center Director

Subject: **Combined Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York**

To: VISN 2 Network Director (10N2)

1. Attached, please find the responses to the recommendations provided in the above cited OIG/CAP report.

2. Questions may be directed to Mr. Eric D. Yeager, Performance Manager at (315)-425-4400.

Director Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommend that the Acting VISN Director ensure that the Medical Center Director takes actions to:

a. Conduct contract file reviews to ensure compliance with the FAR, the VAAR, VA policy, and VHA policy.
b. Recover overpayments from the affiliate for cardiology services and establish controls to prevent future duplicate service contracts.
c. Strengthen controls to prevent apparent conflicts of interest, and if required, seek and abide by VA Regional Counsel's opinion.
d. Correct the required pre-award and post-award administrative deficiencies and strengthen controls and oversight to prevent deficiencies on future contracts.
e. Ensure COTRs receive training as specified by VA policy.

Concur **Target Completion Date: August 1, 2006**

(a) The HCA will implement an ongoing internal control oversight program for reviewing contract files to ensure that necessary documentation is included in the contract file and that regulation and policy directives are being consistently and effectively followed. The oversight program will utilize a standardized contract file checklist as a tool in documenting the results and any necessary corrective action required.

Results will be documented, summarized, and reported by the HCA to the Network Chief Logistics Officer and VAMC Directors on a quarterly basis.

As part of this process, feedback will be provided to contracting officers regarding the contract file reviews and feed-forward loops created to share results and related improvement activities with the entire contracting staff. Performance reporting will be trended and provided to senior management to document results and drive improvement activities. Corrective actions and related process improvements will be addressed as needed.

(b) On May 6, 2006, a meeting was held with the Department Chair for Medicine and his Business Office Manager. In attendance for the VA was the Chief of Staff, the Medical/Surgical Care Line Manager and a Contract Specialist. The meeting discussed contracts and the issue of overpayments in addition to the Inspector General review. The $9,200.00 overpayment for services provided under contract when a staff cardiologist was on duty has been recovered.

Also, the affiliate billed the medical center for cardiology services at the rate of $500 per day for 266 days totaling $133,000 during the period August 11, 2004 to July 17, 2005. The medical center should have been billed at the $75 per visit rate for 296 visits totaling $22,200. As a result, the medical center overpaid the affiliate for cardiology services in the amount of $110,800 ($133,000–$22,200). A bill of collection for $110,000.00 has been prepared and will be delivered to the Business Manager for the Department of Medicine Upstate Medical University.

This activity was discussed in detail at the May 8, 2006 Compliance Board Meeting. All contracts will be tracked through the Compliance Board to ensure action is taken prior to expiration. In addition, the results of the Inspector General Review will be discussed at the June Deans Committee Meeting.

Target Completion Date: Phase I, complete by June 15, 2006, Phase II, ongoing

(c) The HCA has developed a Conflict of Interest (COI) questionnaire designed to determine if a potential conflict of interest is present. The COI Questionnaire will be deployed in two phases. Phase 1 will focus on sending the questionnaire to all existing COTRs assigned to any contract with an affiliate. Depending on the responses, changes to COTR appointments may be necessary. Phase 2 will focus on using the questionnaire prior to COTR appointments for a new contract with affiliates. Completed questionnaires will be sent to the Contracting Officer for initial review. The CO will then forward the completed questionnaires to Medical Center Directors, Associate Directors, Regional Counsel, and Chiefs of Staff. Depending on the responses, action will be taken as appropriate to cancel COTR appointments and initiate new appointments as necessary. Coordination with affected parties will be the responsibility of the CO. A copy of the questionnaire is attached.

(d) VISN 2 has recently deployed a standardized contract checklist created by the National Standard Operating Procedures workgroup to ensure uniformity for all contract files. Quarterly audits will be conducted in accordance with the auditing plan recently implemented. This plan will identify strengths, weaknesses and areas for improvement.

Target Completion Date: Phase I – July 1, 2006, Phase 1I – August, 1, 2006, Phase III – Ongoing

A new training program has been made available for COTRs via CAMEO. A list of COTRs will be compiled and updated as they complete training.

If existing COTRs do not complete the mandatory training by July 1, 2006, a notice will be sent to their supervisor informing them of the failure to complete training.

If existing COTRs do not complete the training by August 1, 2006 a delinquent notice will be sent to the Medical Center Director informing him of the COTRs who have failed to complete the training. COTRs will either be required to take the training or a new COTR will be assigned.

Phase III – as new COTRs are identified they will be required to complete the cameo training prior to their delegation.

Recommendation 2. We recommend that the Acting VISN Director ensure the Medical Center Director reviews the amount of contract interventional services needed and take steps to improve the cost efficiency of outsourced radiologist services.

Concur Target Completion Date: August 1, 2006

The Medical Center Director agrees with the recommendation. To improve the cost efficiency of outsourced radiology services, the current Interventional Radiology contractual agreement will be terminated at the end of June, 2006. A Request for Proposal for competitive bid has been circulated to assist in the reduction of costs. Also, discussions have begun with our affiliate, Upstate Medical University- Imaging department to consider sharing an interventional radiologist with us to ultimately decrease the number of hours needed for contract coverage. Additionally, the Medical Center will also be able to reduce the amount of outsourced radiology services needed since the Radiology Chief has recently completed training that will enable him to provide interventional radiology services.

Recommendation 3. We recommend that the Acting VISN Director ensure that the Medical Center Director requires that:

a. A 100 percent wall-to-wall inventory is completed to identify all sensitive equipment on hand.
b. Responsible officials document and notify A&MMS of all blank, incorrect, and incomplete data fields for the equipment listed on their EIL, for correction in AEMS/MERS during annual EIL inventories.
c. A&MMS staff reviews the "out of service" equipment listing to ensure that it is accurate and being used for its intended purpose.
d. A&MMS staff requires and maintains complete documentation for disposed equipment.

e. ROS are completed for all equipment that is lost, stolen, damaged, or destroyed.
f. Sensitive equipment, regardless of acquisition cost, is listed on an EIL and physically verified during annual EIL inventories.
g. Property leased for more than 90 days is listed on an EIL and physically verified during annual EIL inventories.
h. Responsible officials physically verify all equipment assigned to them during annual EIL inventories.

The Medical Center Director concurs with the OIG finding and is implementing the following initiatives:

Concur Target Completion Date: January 31, 2007

(a) Based on the sensitive item listing compiled by the Network, the following items have been assigned to the following departments to identify all sensitive equipment on hand:

- Information Systems: Computers, monitors, printers, personal computers, lap tops, palm pilots.
- Telecommunications: Cell phones, black berries
- A&MMS: Copiers
- FMS & Police: Hand held radios
- Individual Departments: Fax machines, scanners, VCR, Digital Cameras, and DVD Recorders

The Chief of AM&M will work with the areas listed above to perform a wall-to wall sensitive equipment inventory to identify and add items to the EILs. A&MMS will monitor all services to ensure inventory of moved, stolen or replaced equipment.

(b) Careline Manager's will be designated Responsible Official's (RO's) for their respective areas and will have multiple sub-RO's assigned with formal delegation letters which will be maintained by A&MMS. Careline Manager's and Sub-RO's will attend a training class to outline responsibilities and provide information regarding the different fields in the EIL. The Careline Mangers will then be

given a listing of the incomplete data fields for there area and will work with A&MMS to correct these entries.

(c) A&MMS staff will review the "out of service" equipment listing and make corrections.

(d) A&MMS will develop a standardized format to document disposed equipment. In addition, the Careline Manager's and sub-RO's will be provided training regarding the new documented format. The documentation will be maintained with the EIL for the FY that the disposition occurred.

(e) A&MMS will outline the ROS process and provide training to the Careline Manager's and sub-RO's. The Medical Center will appoint a Board of Survey to include police service. The Police Service will contact A&MMS when ever there is a report of lost, stolen or missing equipment.

(f) Upon completion of the 100% wall-to-wall inventory identified in item a. above, A&MMS personnel will enter the corrected data in AMES/MERS so that it prints out on the EIL. A&MMS will provide training to the Careline Manager's and sub-RO's relative to their duties when performing annual inventories. A&MMS personnel will independently verify the accuracy of the annual inventories.

(g) All items leased for more than 90 days will be identified and added to the appropriate EIL. The Careline Manager's and sub-RO's will work with A&MMS to annually physically verify every item listed on their respective EIL. A&MMS personnel will independently verify the accuracy of the annual inventories.

(h) The Careline Manager's and sub-RO's will physically verify every item on their respective EIL annually. A&MMS personnel will independently verify the accuracy of the annual inventories.

Recommendation 4. We recommend that the Acting VISN Director ensure the Medical Center Director takes action to:

a. Maintain documentation to track and document the status of computer hard drives through final sanitation and disposition.
b. Improve physical security of the communication closet door at the Rome CBOC.
c. Install motion detection alarm systems where noted.
d. Ensure all individuals with access to AIS resources complete required annual security awareness training.
e. Initiate a full BI on the identified IRM employee and follow-up on the four pending BIs.
f. Implement an automatic session timeout feature on all medical center workstations.

Concur Target Completion Date: December 31, 2006

The Medical Center Director agrees with the findings and recommendations and has implemented the following actions:

(a) Hard drive serial numbers and computer EE number are now recorded on the *Excess Personal Computer Equipment sheets* and maintained until destruction.

(b) All IT equipment has been removed from the communication closet at the Rome CBOC and has been relocated to the secure switch room at Rome.

(c) Motion detection for the computer room and the switch room has been added to the *Station Level Needs List*. Funding is not available in FY 2006. Approved for construction beginning in early FY 2007.

(d) The ISO recently participated in hospital wide training day. Information related to security awareness was distributed and the timely completion of annual security training was emphasized. In addition, computer access will be removed from any employee failing to complete annual security awareness training until training is complete.

(e) Paperwork for a full BI has been given to the employee for completion. The ISO will follow-up monthly with HR on the remaining four investigations to ensure timely completion.

(f) VISN 2 has tested and is in the process of phasing in Ace Screensaver. This screensaver has been approved by the Office of Cyber and Information Security.

Recommendation 5. We recommend that the Acting VISN Director ensure that the Medical Center Director requires that verification of current certification of non-VA facilities providing mammography services to VA patients is obtained and retained at the medical center**.**

Concur **Completed**

In response to the recommendation listed above, all facilities that have provided Mammography services to our patients have been contacted and we have received verification of their current certificate to provide mammography services. These are maintained in the Women's Health Clinic.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1b	Better use of funds by recovering overpayments for cardiology services from the affiliate.	$120,050
2	Better use of funds by improving the cost efficiency of outsourced radiology services.	81,996
3a	Better use of funds by improving accountability of sensitive equipment.	22,483
	Total	$224,529

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Philip D. McDonald 781-687-3140
Acknowledgments	Annette Acosta Maureen Barry Stephen Bracci Michael Cannata John Cintolo Matthew Kidd Jeanne Martin James McCarthy Patricia McGauley Sunil Sen-Gupta Hope Watt-Bucci

Appendix E

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