Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Huntington, West Virginia

Report No. 05-03281-168 July 17, 2006

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of October 17–24, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Huntington, WV Medical Center (hereinafter referred to as the medical center). 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 156 employees. The Medical Center is under the jurisdiction of Veterans Integrated Service Network (VISN) 9.

Results of Review

The CAP review focused on 12 areas. The medical center complied with selected standards in the following five activities:

- Accounts Payable
- Accounts Receivable
- All Employee Survey Results
- Environment of Care
- Radiology and Laboratory Wait Times

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

- Implement coordinated interdisciplinary treatment plans to manage patients with colorectal cancer.
- Notify the patients of their right to file claims, and document these notifications in the patients' medical records.
- Strengthen accountability for nonexpendable equipment and equipment that is sensitive in nature.
- Strengthen controls over the Government purchase card program.
- Improve the controlled substances inspection program.
- Strengthen controls over information technology (IT) security.
- Improve supply inventory management by reducing stock levels.

This report was prepared under the direction of Randall Snow, JD, Associate Director, and Carol Torczon, RN, MSN, ACNP, CAP Review Coordinator, Office of Inspector General, Office of Healthcare Inspections, Washington, DC Region.

VISN 9 and Medical Center Director Comments

The VISN 9 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendices A and B, pages 12–20, 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 fully accredited 80-bed acute medical and surgical care facility, offering primary care, outpatient mental health services, and subspecialty outpatient care. VA staffed community based outpatient clinics are located in Charleston, WV, and Prestonsburg, KY. In addition, contract community based outpatient clinics have been established in Logan and Williamson, WV. This Medical Center is the principal teaching facility for the Marshall University School of Medicine for undergraduate and postgraduate medical education. The medical center is also affiliated with Kentucky's Pikeville School of Osteopathic Medicine. The Robert C. Byrd Clinical Addition opened in 1993 and included expansion of surgery, radiology, laboratory, cardiology, nuclear medicine, and rehabilitation medicine services, as well as renovation of inpatient care units. The medical center completed a $10 million research facility in 1998 that houses state-of-the-art research laboratories and support facilities. Extensive use of community resources and contract community nursing homes for post-hospitalization care complement the medical center's treatment programs.

Programs. The medical center has 80 acute care hospital beds and provides a full range of primary and tertiary health care services. The medical center operates several regional referral and treatment programs, including Cardiology, Cardiac Catheterization, Electrophysiology, Outpatient Substance Abuse and Post-Traumatic Stress Disorder programs, Dialysis, Surgery, and a state-of-the-art research facility.

Affiliations and Research. The medical center is affiliated with the Marshall University School of Medicine and the Pikeville School of Osteopathic Medicine.

Resources. The medical center's fiscal year (FY) 2005 medical care budget was $98,133,254. This is exclusive of Medical Care Collection Fund collections, alternative revenues, and specific purpose dollars. FY 2005 (as of July 31, 2005) staffing was 831.6 full-time equivalent employees, which included 64 physicians, 202 nurses, and 5 nurse practitioners.

Workload. In FY 2005 (as of July 31, 2005) the medical center treated 28,263 patients. The medical center provided 18,896 inpatient days of care in acute care. The inpatient care workload totaled 3,370 discharges, and the average daily census, including nursing home patients, was 62.5. The outpatient workload was 241,715 visits.

Objectives and Scope of the CAP Review

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

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

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

Accounts Payable	Equipment Accountability
Accounts Receivable	Government Purchase Program
All Employee Survey Results	Information and Technology Security
Colorectal Cancer Management	Quality Management
Controlled Substances Accountability	Radiology and Laboratory Wait Times
Environment of Care	Supply Inventory Management

The review covered facility operations for FY 2003 through July 31, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews

As part of this review, we followed up on the recommendations resulting from a prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center Huntington, West Virginia*, Report No. 02-02939-82, April 15, 2003). During this CAP review, we determined that the medical center continues to need improvement in supply inventory management and controlled substances accountability.

As part of the review, we interviewed 30 patients to survey patient satisfaction with the timeliness of service and the quality of care. We discussed the interview results with medical center managers.

During this review, we also presented three fraud and integrity awareness briefings. 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.

In this report we summarize selected findings and make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section titled "Other Observation" have no reportable conditions.

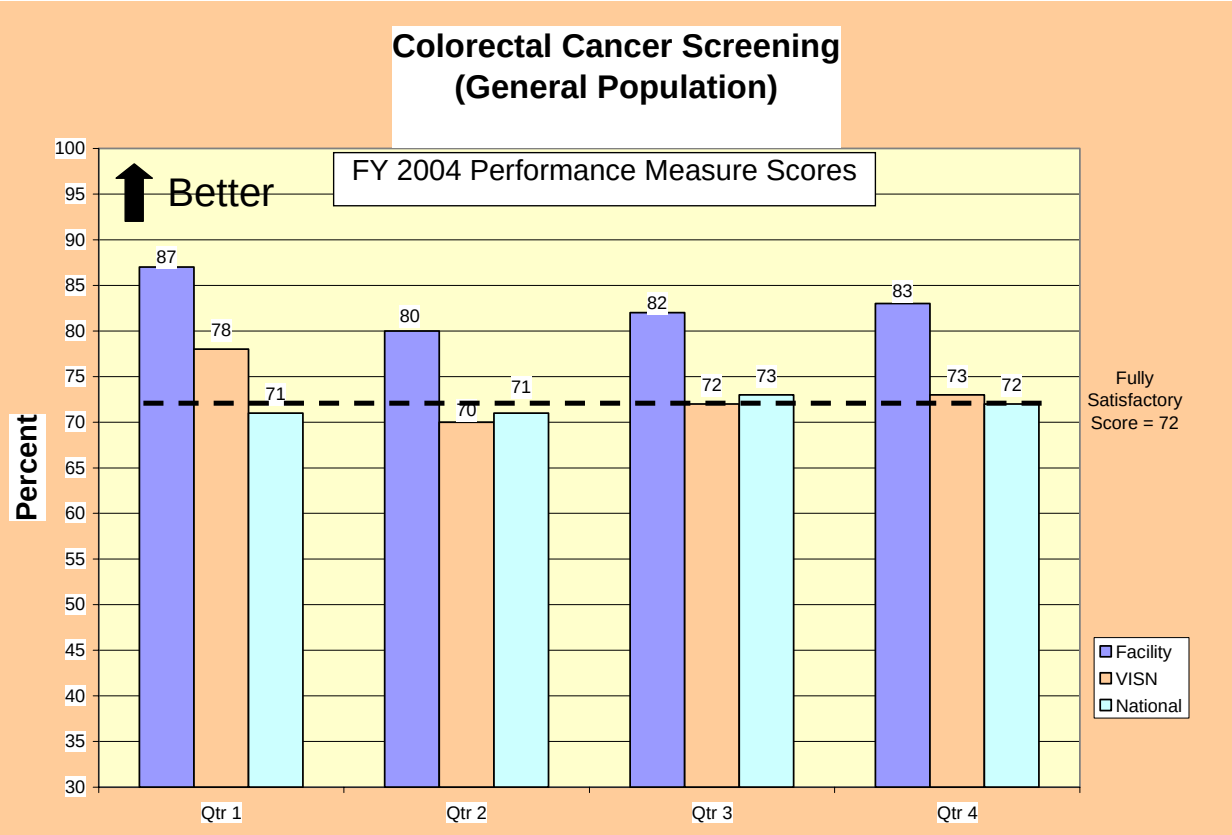
Results of Review

Opportunities for Improvement

Colorectal Cancer Management – Interdisciplinary Treatment Planning Documentation Needed Improvement

Conditions Needing Improvement. The medical center did not have coordinated interdisciplinary treatment plans to manage patients with colorectal cancer. The medical center met the VHA performance measure for colorectal cancer screening; provided timely GI, Surgery and Hematology/Oncology consultative and treatment services; and promptly informed patients of diagnoses and treatment options.

Criteria. The VHA colorectal cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed a judgment sample of 10 patients who were diagnosed with colorectal cancer during FY 2004. To determine reasonableness, we used a 90-day goal for GI evaluation (taking into consideration factors outside the facility's control).



Patients appropriately screened	Patients diagnosed within 90 days	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatment
9/10	**7/10**	**7/10**	**1/10**	**9/10**

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director (a) develop a consistent method for interdisciplinary evaluation of colorectal cancer patients and (b) document interdisciplinary coordination in the patient medical record.

Quality Management – Adverse Outcome Discussions Needed Improvement.

Conditions Needing Improvement. The QM program was generally effective. Appropriate review structures were in place for 11 of the 12 program areas reviewed, but 1 area needed improvement.

Adverse Outcome Discussions. When clinical managers discussed adverse outcomes with patients and their families, they needed to notify the patients of their right to file claims and document these notifications in the patients' medical records. VHA and medical center policy requires staff to discuss adverse outcomes with patients and to inform them of the right to file tort or benefit claims. During FY 2004–2005, responsible clinicians documented adverse outcome discussions with two patients but did not advise one of these patients of their right to file claims.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that clinical staff advise all patients who experience adverse outcomes of their rights to file claims and document the notification in the patients' medical record.

Supply Inventory Management – Stock Levels Needed To Be Reduced

Conditions Needing Improvement. The medical center needed to reduce stock levels of supplies. VHA policy establishes a 30-day supply goal and requires that medical facilities use the automated Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, the medical center's supply inventory included 2,046 line items valued at $301,839. To assess the accuracy of GIP and PIP data, we inventoried 50 line items with a combined recorded value of $29,870 and found that the stock levels recorded in GIP and PIP were accurate.

We also compared the quantities on hand to usage data for the 50 line items that we inventoried to determine if stock levels exceeded the 30-day supply goal. Our review showed that the medical center needed to reduce stock levels for 16 (32 percent) of the 50 line items. The value of the excess stock was $4,675, which was 16 percent of the total value ($29,870) of the 50 items we inventoried. Based on the results of our inventory, we estimated that the value of the excess stock was $48,294 ($301,839 x 16 percent).

Recommended Improvement Action 3. We recommend that the VISN Director ensure the Medical Center Director requires that stock levels be reduced to meet the 30-day supply goal.

Equipment Accountability – Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center managers needed to improve procedures to account for nonexpendable equipment (items acquired for $5,000 or more with an expected useful life of 2 or more years) and equipment that is sensitive in nature (susceptible to theft or conversion to personal use). VA policy requires the completion of periodic inventories to ensure equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). As of September 2005, the medical center had 105 active EILs containing 1,305 items valued at about $31 million. We identified two areas that needed improvement.

Timeliness of Inventories. VA policy requires medical center staff to complete inventories of nonexpendable equipment within 10 days of notification (20 days if the EIL contains 100 or more items) and requires Acquisition and Materiel Management Service (A&MMS) staff to send delinquency notices to responsible officials when inventories are overdue. We reviewed 51 inventories completed during the 7-month period ending September 30, 2005, and found that 21 (41 percent) were not completed on time. The 21 inventories were completed 12 to 150 days after they were due. According to A&MMS staff, they did not consistently follow up on delinquent inventories or send delinquency notices to the officials who were responsible for conducting the inventories.

Accountability of Equipment. VA policy requires responsible officials, such as service chiefs or their designees, to certify that they have maintained proper accountability of equipment by signing and dating their EILs after they have inventoried their equipment. During our review, we identified 19 items valued at about $409,000 that were listed on the medical center's EILs but located at the VA Regional Office (VARO) Huntington, WV. Medical center staff had not maintained accountability of the 19 items for several years. According to VARO staff, seven of the items had been turned in (some turn-ins occurred as far back as 1997) and three other items had not been used for several years. VA policy also requires that sensitive items, such as computer equipment, be accounted for regardless of cost, life expectancy, or maintenance requirements. To evaluate the accountability of sensitive items, we selected five items valued at about $10,000 and

found that four of the items valued at about $4,500 were not listed on the medical center's EILs.

Recommended Improvement Action 4. We recommend that the VISN Director ensure the Medical Center Director requires that: (a) inventories of nonexpendable property be completed within required timeframes, (b) A&MMS staff follow up on all delinquent inventories, (c) medical center staff take appropriate actions to inventory and regain accountability of the EIL items located at VARO Huntington, and (d) sensitive items be added to EILs.

Government Purchase Card Program – Controls Needed To Be Strengthened

Conditions Needing Improvement. The medical center needed to strengthen controls over the Government Purchase Card Program. We evaluated the effectiveness of management controls designed to detect inappropriate purchases made by medical center employees using their Government purchase cards. Our review covered the transactions that occurred during the 6-month period ending August 31, 2005. The purchase card program included 30 cardholders and 20 approving officials, who made about $4 million in purchases during the 6-month period. During our review, we identified four issues that required management attention.

Timeliness of Reconciliations. VHA policy requires cardholders to reconcile 75 percent of their transactions within 10 calendar days after receipt of billing information and 95 percent of their transactions within 17 calendar days. All of the transactions must be reconciled within 30 calendar days. The medical center met the 75 percent timeliness standard for all 6 months we reviewed, and it met the 95 percent timeliness standard for 5 of the 6 months. However, medical center cardholders did not reconcile all transactions within 30 calendar days during any of the months in the 6-month period.

Warrant Authorities. Cardholders must be warranted through the Contracting Officer Certification Program to exceed the micro-purchase authority of $2,500. VHA policy also requires approving officials to be warranted at the same level or higher than the cardholders they monitor to ensure they have adequate knowledge of acquisition regulations, which is needed to properly monitor cardholders. We reviewed 10 purchases greater than $2,500 that were made by 6 different cardholders to determine whether the cardholders had appropriate warrant authorities. Our review showed that one cardholder made a purchase that exceeded his warrant authority of $50,000. During the 6-month period ending August 31, 2005, this cardholder made four additional purchases that exceeded his warrant authority. The total value of the five purchases was $298,587. Of 10 approving officials who were responsible for monitoring cardholders who were authorized to exceed the micro-purchase authority, 9 did not have appropriate warrant authorities.

Competitive Procurements. The Federal Acquisition Regulation requires purchase cardholders to use competition to obtain supplies and services at the best prices. For purchases exceeding $2,500, cardholders must consider prices from three sources or document their justifications for using sole sources. To determine whether the medical center obtained adequate competition, we reviewed 10 purchase card transactions exceeding $2,500 and found that cardholders made 2 purchases totaling $29,536 without considering prices from 3 sources or documenting their justifications for sole source procurements.

Training Documentation. VA policy requires that cardholders and approving officials attend training courses on the use of the purchase card as well as ethics and standards of conduct prior to obtaining their Government purchase cards. The cardholders and approving officials must certify that they have received the training, understand the policies and procedures, and know the consequences of inappropriate actions by signing the Governmentwide Purchase Card Certification (VA Form 0242). We reviewed the training files for all of the medical center's cardholders and approving officials and found that none of the files contained VA Form 0242s.

Recommended Improvement Action 5. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) cardholders meet the timeliness standards for reconciling transactions, (b) cardholders comply with their warrant authorities, (c) approving officials be warranted at the same level or higher than the cardholders they monitor, (d) cardholders consider prices from three sources for purchases exceeding $2,500 or justify sole source procurements, and (e) VA Form 0242s be signed and retained for all cardholders and approving officials.

Controlled Substances Accountability – Inspection Program Needed To Be Improved

Condition Needing Improvement. The medical center needed to strengthen its controlled substances inspection program. To evaluate the medical center's inspection program, we reviewed inspection reports for the 8-month period from January through August 2005, interviewed inspectors, and observed unannounced inspections of selected areas where controlled substances were stored and dispensed. We identified two areas that needed improvement.

Monthly Inspections. VHA policy requires medical facilities to conduct unannounced inspections of all storage and dispensing locations for controlled substances each month. VHA policy also requires that excess controlled substances be removed from pharmacy stock at the time of the monthly inspection and that inspectors verify the accuracy of records in inpatient units, clinics, and research laboratories. During our observation of a controlled substances inspection on October 19, 2005, we found a controlled substance in Research Service that had expired on June 5, 2005. The expired controlled substance was

not discovered until the inspector was prompted by the auditor to check the expiration date. In addition, we observed that the inspectors did not verify that the controlled substances and strengths dispensed matched the controlled substances and strengths recorded in hard copy and electronic records.

Inspection Checklists and Reports. The medical center could improve its controlled substances inspection program by using inspection checklists and a detailed monthly inspection report. The inspectors we observed did not use any resources to help them conduct their inspections in a systematic way. Providing the inspectors with detailed, step-by-step checklists to follow while they conduct their inspections would result in more thorough and comprehensive inspections. In addition, the monthly inspection reports that we reviewed varied significantly from month to month in the level of detail and did not contain sufficient information to show that the medical center's inspection program was operating effectively. The Controlled Substances Coordinator and pharmacy staff implemented local policy changes while we were onsite by developing a new inspection checklist and a more detailed monthly inspection report format. These changes should improve the medical center's controlled substances inspection program.

Recommended Improvement Action 6. We recommend the VISN Director ensure the Medical Center Director requires that controlled substances inspectors: (a) review expiration dates for controlled substances; (b) verify the accuracy of records in inpatient units, clinics, and research laboratories; and (c) perform comprehensive monthly inspections and report results in sufficient detail by using the medical center's newly developed inspection checklist and monthly report format.

Information Technology Security – Controls Needed To Be Strengthened

Condition Needing Improvement. Medical center managers needed to strengthen controls over IT security. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, or misuse and ensured continuity of operations following a disruption or disaster. We identified four areas that required management attention.

System Access. VA policy requires that facilities terminate IT system access privileges when employees leave the organization. VHA policy requires facilities to review employees' access at least every 90 days to ensure that levels of access are appropriate and that continued access is needed. In addition, VHA policy requires facilities to disable access to accounts that have been inactive for 90 days. During our review, we identified one employee whose access to the Veterans Health Information System and Technology Architecture (VistA) was not terminated even though the employee ended employment with the medical center on July 21, 2005. In addition, we identified 10 employees whose VistA account settings prevented their accounts from being automatically disabled after 90 days of inactivity. Although eight of the employees' accounts had been accessed

within 90 days, two of the employees should have had their access privileges disabled because they had not accessed their VistA accounts since October 21, 2004, and February 3, 2005, respectively.

Contingency Plans. The medical center's contingency plan for its local area network (LAN) did not adequately address how to respond to emergencies and restore the LAN in the event of an IT system disruption. A contingency plan addresses the procedures for responding to emergencies, backing up data files and storing backup tapes offsite, ensuring that essential business functions can be conducted after disruption of IT support, and restoring facility processing capability. Although the medical center's VistA contingency plan was comprehensive, the contingency plan for the LAN did not include detailed procedures for responding to emergencies and restoring the LAN after an IT system disruption.

Communications Closet Security. VA policy requires that access to network infrastructure components, such as communications closets, be limited to IT support personnel. Communications closets are secured rooms containing network and telecommunications equipment and wiring that support critical IT functions. We reviewed the physical security of 10 communications closets and found that the door to 1 of the communications closets was unlocked. This occurred because the medical center was also using the communications closet as a storage room.

Security Awareness Training. VA policy requires that all VA employees who have access to IT systems complete cyber security awareness training every year. During FY 2005, 58 (6 percent) of 992 medical center employees with access to IT systems did not complete the required training.

Recommended Improvement Action 7. We recommend the VISN Director ensure the Medical Center Director requires that: (a) access to IT systems be promptly terminated when employees terminate employment with the medical center, (b) employees' VistA accounts be set to ensure that access is automatically disabled after 90 days of inactivity, (c) the LAN contingency plan include detailed procedures for responding to emergencies and restoring the LAN after an IT system disruption, (d) access to communications closets be secured and limited to IT support personnel, and (e) all medical center employees with access to IT systems complete required cyber security awareness training annually.

Other Observation

All Employee Survey

The *Executive Career Field (ECF) Performance Plan* for FY 2005 directs the VISN to ensure that results from the 2004 All Employee Survey (AES) are widely disseminated throughout the network by, at a minimum, conducting a town hall meeting open to all

employees at each facility during the rating period. VISNs were to have analysis of the 2004 AES results, with formulation of plans to address action items for improvements, completed by September 30, 2004. Plans must demonstrate milestones that include time lines and measures that assess achievement.

The medical center met all requirements of Performance Measure 22, *ECF Performance Plan* for FY 2005. The AES coordinator obtained results from the ProClarity website and disseminated them to the employees by newsletter and staff meetings. Action plans were developed on the facility and service line level. A follow-up survey was conducted in three service areas that had the lowest scores, and the results were sent to the National Center for Organization Development for tabulation and analysis. The results were not yet available at the time of the CAP Review. The medical center also developed and implemented a two-level leadership training program, which has enjoyed high employee participation.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 25, 2006

From: Network Director (10N9), VA Mid South Healthcare Network (10N9)

Subject: **VA Medical Center Huntington, West Virginia**

To: Assistant Inspector General, Office of Healthcare Inspections
Thru: Director, Management Review Service (10B5)

1. Attached is the response to recommendations noted in the most recent Combined Assessment Program Review of the Department of Veterans Medical Center, Huntington, West Virginia, conducted October 2005.

2. If you have any questions or need additional information, please contact Warren Hill, Acting Medical Center Director, Huntington VAMC or Donna Savoy, Staff Assistant to the Network Director, VISN 9.

(original signed by:)

John Dandridge, JR.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 15, 2006

From: Acting Director, Huntington VA Medical Center

Subject: **VA Medical Center Huntington, West Virginia**

To: Director, VA Mid-South Healthcare Network, (10N9)

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

(original signed by:)
Warren E. Hill

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director:

(a) develop a consistent method for interdisciplinary evaluation of colorectal cancer patients, and

Concur **Target Completion Date:** July 14, 2006

An *Interdisciplinary Colorectal Cancer Treatment Note* will be developed. At the time of diagnosis of colon cancer, the note will be initiated and have input from Surgery, Oncology, Gastroenterology and Primary Care as well as other disciplines as indicated.

(b) document interdisciplinary coordination in the patient medical record.

Concur **Target Completion Date:** July 14, 2006

This note will also serve to document the interdisciplinary coordination of care in the patient medical record.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that clinical staff advise all patients who experience adverse outcomes of their rights to file claims and document the notification in the patients' medical record.

Concur and Ongoing **Target Completion Date:** Completed

Medical Center Memorandum (MCM) PCI-52: *Informing Patients About Adverse Events* was updated to include all elements of VHA directive "Disclosure of Adverse Events", dated January 2005. A documentation template titled "Disclosure of Adverse Event Template", which also meets the requirements of the VHA directive, is available in the Computerized Patient Record System (CPRS) to all practitioners for documentation of disclosure.

The Quality Manager and Patient Safety Manager will review patient records, based on criteria established in MCM PCI-52, for evidence of disclosure. If documentation is not found in the patient record, the Quality Manager and/or Patient Safety Manager will follow-up with the appropriate Service Chief to ensure discussion and follow-up documentation occurs as outlined in the memorandum. The Patient Safety Manager will keep a log of each event requiring disclosure and the documentation of follow-up as it occurs.

Recommended Improvement Action 3. We recommend that the VISN Director ensure the Medical Center Director requires that stock levels be reduced to meet the 30-day supply goal.

Concur **Target Completion Date:** Completed

We concur that there may be some items that could be reviewed for possible reduction of stock, however, many of the items are "just-in-case" or infrequent use items that must be maintained, even though they impact the average days of stock on hand. The "Days of Stock on Hand" report utilized for the OIG review was queued to run with the parameter of showing only items greater than 20 days supply and doesn't take into account the total days of stock on hand for the entire inventory as stated in VHA Handbook 1761.2, VHA Inventory Management.

Although there were specific line items identified in the GIP account with quantity on hand that appears to be in excess of 30 days, the average stock level for SPD routinely averages 30 days stock on hand (12 turns), or less. In accordance with VHA Handbook 1761.2 Paragraph 5.b., it is the average that is required to be 30 days, not the individual line items. For the clinical areas, just-in-case items that turn very slowly are offset by the items that turn very quickly, thereby enabling the inventory account to maintain an average of 12 turns, or 30 days stock on hand. The following average turn rates were taken directly from the Stock Status Report. This is the report that is submitted to the VHA Clinical Logistics Office monthly.

Month	SPD	Month	SPD
Apr 05	10.77	Jul 05	7.88
May 05	7.52	Aug 05	9.19
Jun 05	8.52	Sep 05	7.95

Huntington A&MMSL has an established process for reviewing excess and inactive supplies at the quarterly Commodity Standards Board Meeting. This process will continue to assure that inactive items are excessed in accordance with the property regulations.

Recommended Improvement Action 4. We recommend that the VISN Director ensure the Medical Center Director requires that:

inventories of nonexpendable property be completed within required timeframes;

Concur **Target Completion Date:** Completed

A&MM Service Line staff at Huntington VAMC updated our interoffice memorandum notifying the responsible official and/or designee of the required time frames for completion of inventories for non-expendable equipment. A&MMSL VISN 9, recommendation is that the NX Clerk is responsible to scan all EIL's and Non-EIL's.

A&MMS staff follow up on all delinquent inventories;

Concur **Target Completion Date:** Completed

As discussed in (a) the NX Clerk will use the Intermec 2410 hand held scanner to inventory "All" EIL's and NON EIL's. By utilizing this method/process, the AMES/MERS equipment program will be updated on an annual basis with room number and the actual inventory date. A&MMSL will contact each service a few days prior to the due date of the EIL. To date all EIL's have been updated and returned on time.

medical center staff take appropriate actions to inventory and regain accountability of the EIL items located at VARO Huntington, and

Concur **Target Completion Date:** Completed

The NX Clerk physically inventoried with the assistance of the VARO staff "All" EIL equipment. This was completed October 2005. A&MMSL, Huntington will follow-up with the VARO in October 2006 to perform a spot check of the EIL.

sensitive items be added to EILs.

Concur **Target Completion Date:** Completed

Additional sensitive items have been identified and picked up in accordance with VHA Handbook 7127/4, dated October 11, 2005.

Recommended Improvement Action 5. We recommend the VISN Director ensure that the Medical Center Director requires that:

cardholders meet the timeliness standards for reconciling transactions,

Concur **Target Completion Date:** Implemented

The Agency Organization Program Coordinator (AOPC) will send reconciliation reminders three times per week to all purchase card holders and approving officials showing the age of pending reconciliations by cardholders.

cardholders comply with their warrant authorities,

Concur **Target Completion Date:** Completed

Due to the increased cost associated with the new Home Oxygen Contract and an increase in the number of patients on home oxygen, the Prosthetics Purchasing Agent's (PA) warrant level was increased from $50,000 to $100,000 against established contracts.

approving officials be warranted at the same level or higher than the cardholders they monitor,

Concur **Target Completion Date:** Pending resolution between FAR and VHA

There seems to be some conflict between the FAR and VHA Handbook 1730.1 on Approving Officials being warranted at the same level or higher than a cardholder. Contracting Officer's decision cannot be subject to change by an Approving Official, as described in VHA Handbook 1730.1, Paragraph 11.a. Contracting Officers are the approving official for an acquisition award, in accordance with FAR 1.602-1 Authority and 1.602-2 Responsibilities. Approving Official, as referenced in VHA Handbook 1730.1, is the individual or position authorized to approve a REQUEST for an expenditure of funds and to certify that funds are available in their assigned fund control point, however only a Contracting Officer can approve the actual expenditure of funds. An Approving Official from a fiscal perspective is not a contracting officer, therefore cannot be warranted and cannot approve a Contracting Officer's award decision. The requirement in VHA Handbook 1730.1, paragraph 11.a, violates FAR regulations.

cardholders consider prices from three sources for purchases exceeding $2,500 or justify sole source procurements, and

Concur **Target Completion Date:** Completed

All Item Managers, Purchasing Agents, and Inventory Management Specialist(everyone with a regulation warrant) have completed refresher Purchase Card Training dealing with various Purchase Card Requirements within the last six months. The supporting documentation is located in each Purchase Card Holder File and has been entered into VISTA/Tempo.

VA Form 0242s be signed and retained for all cardholders and approving officials.

Concur **Target Completion Date:** Completed

A new process has been established in A&MMSL to ensure all required forms, training and documentation is included in the Purchase Card Holder File before the purchase card is requested from Citibank.

Recommended Improvement Action 6. We recommend the VISN Director ensure the Medical Center Director requires that controlled substances inspectors:

review expiration dates for controlled substances;

Concur **Target completion Date:** Completed

Narcotic Inspectors are currently reviewing medications for expired dates. Pharmacy is notified immediately of any expired medications found during the narcotic inspection. The expired medications are picked up by Pharmacy and entered in the Controlled Substances package for destruction. The inspector documents the findings on the inspection checklist that inspectors must follow. Findings of expired medications are reported on the inspection memo to the Medical Center Director and are tracked by the CSSO. It has also been included in Medical Center Memorandum QA/IC-5, "Inspection of Controlled Substances".

verify the accuracy of records in inpatient units, clinics, and research laboratories; and

Concur **Target Completion Date:** Completed

Narcotic Inspectors were instructed during local training, February 9, 2006, on the documents used to verify the accuracy of controlled substance documentation. For many of the patient care areas this can be accomplished by reviewing BCMA reports. The CSSO reviews the team's findings and supporting documentation to verify that procedures are being followed. The CSSO will provide further training or follow-up for any areas of concern to Team Leaders and Narcotic Inspectors as needed.

perform comprehensive monthly inspections and report results in sufficient detail by using the medical center's newly developed inspection checklist and monthly report format.

Concur **Target Completion Date:** Completed

Narcotic Inspections are being conducted using the Medical Center's newly developed checklist. Checklists are signed and dated by the Narcotic Inspector(s) following their inspection. Monthly reports have been developed to include detailed information on how the inspection was accomplished in each area. The CSSO reviews the monthly reports

and supporting documentation to verify that all facets of the inspection are being conducted per policy and that supporting documentation is complete. Problems reported in the monthly report are followed to resolution and tracked/trended by the CSSO. Any problems that reflect a pattern are discussed with the service chief or narcotic inspector for correction.

Recommended Improvement Action 7. We recommend the VISN Director ensure the Medical Center Director requires that:

access to IT systems be promptly terminated when employees terminate employment with the medical center,

Concur and Ongoing **Target Completion Date:** Completed (Quarterly)

Procedures are in place to ensure that employees access to IT systems are promptly terminated when leaving employment. IRM/ISO employees are included in the clearance process so that terminations can be done in a timely manner. Additionally, when employees are cleared through the Human Resources Office, a bulletin is generated which notifies appropriate personnel, including IRM/ISO, that an employee has left employment. To correct the oversight identified during the IG audit, additional staff have been included in the distribution of the bulletin to ensure timely termination.

As a follow up, audits are also performed every quarter whereby the service ADPAC reviews all active users for appropriate access. This audit will identify employees who no longer require access.

employees' VistA accounts be set to ensure that access is automatically disabled after 90 days of inactivity,

Concur **Target Completion Date:** Completed

Vista accounts are automatically disabled after 90 days of inactivity. This is done via a nightly routine that checks for inactivity for the past 90 days and sets a field labeled "disuser" to "yes". The "disuser" field has three valid entries: 1) "null" if the user is active; 2) "yes" if the user is disabled, such as after having 90 days of inactivity; or 3) "no" if the user is not to be disabled. The problem encountered during the IG review was that users had previously had the disuser field set to "YES" for 90 days of inactivity. However, when they were reinstated, rather than "deleting" the "YES" flag, the support staff entered "NO", not realizing that this would set the account to never disable. This procedure was reviewed with staff and immediately corrected at the time it was identified by the IG. We do not expect this error to occur again.

the LAN contingency plan include detailed procedures for responding to emergencies and restoring the LAN after an IT system disruption,

Concur **Target Completion Date:** Completed

The LAN contingency plan has been updated to include assignment of staff responsibility for responding to emergencies and restoring the LAN after an IT system disruption.

access to communications closets be secured and limited to IT support personnel,

Concur **Target Completion Date:** June 15, 2006

An inspection of communication closets was conducted by staff from IRM and Facility and Plant Management to review and limit access to IT support personnel wherever possible. The one unsecured communication closet identified during the CAP review has been secured with a lock and access limited. The number of shared communication closets has been reduced from 32 to 20. Within the next 30 days, tighter key controls will be implemented to limit access to shared closets to IT staff and essential personnel. As projects occur, fire alarm and other electronic cabinetry will be removed from shared communication closets.

all medical center employees with access to IT systems complete required cyber security awareness training annually.

Concur **Target Completion Date:** September 30, 2006

Additional efforts have been implemented to ensure all Medical Center employees with access to IT systems will complete the annual Cyber Security Awareness Training. Additional communication efforts include Employee Town Hall Meetings, Monthly Director's Staff Meetings, completion rate updates to service chiefs, e-mail messages, and Medical Center publications.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Reducing stock levels would make funds available for other uses.	$48,294

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Randall G. Snow, Associate Director, Washington, DC Regional Office of Healthcare Inspections
Acknowledgments	Carol Torczon Donna Giroux Gail Bozzelli Jehri Lawson Glen Gowans Heather Jones Clenes Duhon Joel Snyderman Sally Stevens Chau Pham Robert Franco

Appendix E

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