



**Department of Veterans Affairs
Office of Inspector General**

**Combined Assessment Program
Review of the
VA Puget Sound Health Care System
Seattle, Washington**

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 January 24–28, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Puget Sound Health Care System. 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 307 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 20.

Results of Review

The CAP review covered 18 operational activities. The health care system complied with selected standards in the following seven activities:

- Accounts Receivable
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Environment of Care
- Part-Time Physician Timekeeping
- Pharmacy Security
- Unliquidated Obligations

We identified the following organizational strengths:

- Integrated medical and psychiatric emergency services promoted optimal patient management.
- Clinicians reduced patient falls by initiating an effective fall prevention program.

We made recommendations in 11 of the 18 activities reviewed. For these 11 activities, the health care system needed to:

- Ensure that service contracts are properly administered.
- Reduce excess supply inventories and strengthen inventory management controls.
- Reduce delays in insurance billings and collections.

- Strengthen equipment accountability controls.
- Improve compliance with the supply purchasing hierarchy.
- Improve documentation of resident supervision and ensure that patients who have experienced adverse outcomes are informed of their right to file claims.
- Improve documentation of patient skin integrity assessments and identification of patients at risk for developing pressure ulcers.
- Reduce the waiting time from Gastroenterology (GI) consultation to evaluation.
- Develop an action plan to address emergency preparedness vulnerabilities.
- Ensure that Government purchase card transactions are properly monitored.
- Strengthen controls for automated information systems (AIS) resources.

VISN 20 and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 17–28, for the full text of the Directors’ comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Mr. David Sumrall, Director, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Health Care System Profile

Organization. The health care system has two divisions located in Seattle and American Lake, WA, and provides tertiary medical, surgical, psychiatric, and nursing home care services. Outpatient care is also provided at three community-based outpatient clinics in Bremerton, Federal Way, and Shoreline, WA. The health care system serves a population of about 460,000 veterans in Washington, Alaska, Idaho, and Oregon.

Programs. The Seattle campus is a 274-bed facility providing a full range of services in medicine, surgery, and neurology. The American Lake campus is a 230-bed facility that provides outpatient care, substance abuse treatment, a nursing home, and domiciliary care. Special programs include Bone Marrow Transplant, Spinal Cord Injury, Radiation Oncology, Post-Traumatic Stress Disorder (PTSD), and Deployment Health.

Affiliations and Research. The health care system is affiliated with the University of Washington School of Medicine and supports 709 medical residents, interns, and students in 32 training programs. In fiscal year (FY) 2004, the health care system research program had 527 projects and a budget of \$38.9 million. Important areas of research include aging, mental health, and diabetes.

Resources. The health care system's FY 2005 medical care budget was \$388.4 million, a 2 percent decrease from FY 2004 funding of \$395.7 million. FY 2004 staffing was 2,712 full-time equivalent employees (FTE), including 175 physician FTE and 470 nursing FTE.

Workload. In FY 2004, the health care system treated 59,329 unique patients, a 3 percent increase from FY 2003. The FY 2004 inpatient average daily census, including nursing home patients, was 376, and outpatient workload totaled 612,637 patient visits (a 5 percent increase from FY 2003).

Objectives and Scope of the CAP Review

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

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

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

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 18 activities:

Accounts Receivable	Part-Time Physician Timekeeping
Colorectal Cancer Management	Pharmacy Security
Community Nursing Home Contracts	Pressure Ulcer Management
Controlled Substances Accountability	Procurement of Medical and Prosthetic Supplies
Emergency Preparedness	Quality Management
Environment of Care	Service Contracts
Equipment Accountability	Supply Inventory Management
Government Purchase Card Program	Unliquidated Obligations
Information Technology Security	
Medical Care Collections Fund	

The review covered health care system operations for FY 2000 to FY 2005 through January 2005 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 (*Combined Assessment Program Review of the VA Puget Sound Health Care System*, Report No. 01-00071-59, March 16, 2001).

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, and 1,007 employees responded. We also interviewed 30 patients during the review. We discussed the survey and interview results with health care system managers.

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

During the review, we also presented 6 fraud and integrity awareness briefings for 307 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.

Results of Review

Organizational Strengths

Integrated Medical and Psychiatry Emergency Services Promoted Optimal Patient Management. Over a 10-year period, the Psychiatry Emergency Service (PES) evolved from a traditionally consultative role into an emergency room partnership. The PES team is located in the emergency room, facilitating timely and frequent interdisciplinary collaboration and treatment planning. This innovative model promotes optimal, 24-hour a day evaluation and management of patients who have medical or mental health emergencies. A recent example was the treatment of a young veteran who had just returned from Iraq. While the initial plan was to admit the patient for medical concerns, further evaluation and collaboration with the PES team resulted in a more comprehensive treatment plan that included PTSD and substance abuse services.

Initiatives To Reduce Patient Falls Were Effective. Nursing employees on an inpatient ward developed an effective fall prevention program to reduce the incidence of patient falls. Comprehensive fall risk assessments, work area modification, and employee education were introduced to enhance prevention strategies. Nursing staff thoroughly evaluated falls to identify improvement opportunities, which included placing at-risk patients close to the nurses' station and equipping beds with alarms to alert staff when patients left their beds. As a result of these initiatives, patient falls on this ward were reduced by 50 percent.

Opportunities for Improvement

Service Contracts – Preaward Audits Should Be Requested and Contractor Invoices Properly Certified

Conditions Needing Improvement. Management needed to ensure that sole source contracts valued at \$500,000 or more are sent to the VA OIG for preaward audits and that only designated contracting officer’s technical representatives (COTRs) certify contractor invoices. To determine if contract administration procedures were effective, we reviewed 15 service contracts (estimated total value = \$28.3 million) and interviewed the Supervisory Contract Specialist and 7 COTRs.

Preaward Audits of Sole Source Contracts Not Requested. Veterans Health Administration (VHA) policy requires that sole source contracts valued at \$500,000 or more be sent to the OIG for preaward audits. The primary purpose of these audits is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. Three contracts, with an estimated total value of \$10.6 million, met the dollar threshold but were not sent for the required audits. We estimated that preaward audits for these three contracts could have resulted in reduced costs of about \$1.4 million.¹

Contractor Invoices Not Certified by COTR. For each contract, the contracting officer designates a COTR who is responsible for monitoring the contractor’s performance and ensuring that services are provided in accordance with the contract. This responsibility includes reviewing contractor invoices and certifying that the charges accurately reflect the work completed. According to health care system policy, COTRs may not redelegate their authority to another person.

For 10 of the 15 contracts reviewed, employees other than the COTRs had certified the contractor invoices. Accounting and Fee Section staff issued payments based on these certifications. These problems occurred because COTRs were not properly trained on their responsibilities and because Accounting and Fee Section staff did not verify that only designated COTRs had certified invoices.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) all sole source contracts valued at \$500,000 or more are sent to the OIG for preaward audits, and (b) refresher training is provided to COTRs and Accounting and Fee Section staff on responsibilities and procedures for properly certifying and paying invoices.

¹ The OIG has determined that preaward audits result in potential average savings of 21 percent of the proposed contract prices and that 62 percent of the potential savings is sustained during contract negotiations. Applying these percentages to the total estimated value of the three contracts resulted in estimated savings of \$1,377,716 (\$10,581,533 x 21 percent x 62 percent).

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that the purchasing staff will receive refresher training on the preaward requirement and COTRs and Accounting and Fee Section staff will receive refresher training on procedures for certifying and paying invoices. All training will be completed by June 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Conditions Needing Improvement. The health care system needed to manage supply stock levels more effectively and make better use of automated inventory controls. The VHA Inventory Management Handbook establishes a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Excess Medical Supply Inventory. Facilities Management Service (FMS) Distribution Section staff used GIP to manage the medical supply inventory. As of January 18, 2005, the inventory consisted of 1,398 items with a value of \$951,914. To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 medical supply items (value = \$56,553). Fifteen of the items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 32 to 780 days of supply. The estimated value of stock exceeding 30 days was \$24,668, or 44 percent of the total value of the 20 items. By applying the 44 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of the medical supply inventory exceeding current needs was \$418,842 (44 percent of the total inventory value). The excess stock occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-day standard.

Excess Prosthetic Supply Inventory. Prosthetics and Sensory Aids Service (PSAS) had established a 30-day supply standard and managed its inventory with the Prosthetic Inventory Package (PIP), which is similar to GIP. As of January 19, 2005, the PSAS maintained an inventory of 1,113 supply items (value = \$337,941). We reviewed the quantities on hand and usage rates for a judgment sample of 10 items (value = \$58,776). Six of the 10 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 40 to 278 days of supply. The estimated value of stock exceeding 30 days was \$18,049, or 31 percent of the total value for the 10 items. By applying the 31 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of all excess stock was \$104,762 (31 percent of the total inventory value). The excess stock occurred because staff were not properly monitoring inventory levels.

Excess Engineering Supply Inventory. Engineering Service used GIP to manage 1,739 items, or about one-third of its engineering supplies. To test the reasonableness of stock levels, we reviewed the quantities on hand for a judgment sample of 10 engineering supply items (estimated value = \$4,240). Because the service was not using GIP for its entire inventory, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for 7 of the 10 items, with inventory levels ranging from 42 to 600 days of supply. Without sufficient inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded current needs. The Facility Manager acknowledged the need to reduce the inventory and to fully implement GIP controls for all engineering supplies.

Inaccurate Inventory Records. Using the sample of 30 medical and prosthetic supply items that we used to review inventory levels, we compared the recorded GIP and PIP quantities on hand with our actual counts. GIP and PIP inventory records were not accurate for 14 of the 30 items. For all 14 items, some transactions had been incorrectly or incompletely posted to inventory records resulting in inaccurate inventory balances. If inventory balances are not kept current, GIP and PIP cannot accurately track item demand and establish reasonable stock levels and reorder points.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Health Care System Director requires: (a) FMS staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) PSAS staff to monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetics supply inventory; (c) Engineering Service staff to reduce excess engineering supply inventory and to implement GIP for all engineering supplies; and (d) inventory management staff to keep GIP and PIP inventory records current by promptly and accurately posting inventory transactions.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that plans were being implemented to automate inventories and increase their accuracy. The target date for full implementation of these plans is December 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medical Care Collections Fund – Collection Delays Should Be Reduced and Clinical Documentation Improved

Conditions Needing Improvement. Health care system management needed to ensure that outstanding bills are pursued aggressively and clinical documentation is completed. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain insured veterans.

Bills Not Promptly Followed Up. As of November 30, 2004, the health care system had 15,002 insurance bills with a total value of \$7.1 million (excluding bills referred to the VA Regional Counsel for collection). Of these, 7,823 bills were more than 90 days old (value = \$3.2 million, or 45 percent of the total value).

To evaluate collection efforts, we reviewed 50 bills that were more than 90 days old (value = \$2.2 million). Thirty-one of these bills had been appropriately cancelled, reissued, or collected after we began our review of the sample. However, based on our review and discussions with the Accounts Receivable Supervisor the remaining 19 bills required more aggressive collection efforts (value = \$1.1 million, or 50 percent of the \$2.2 million total value).

MCCF staff waited an average of 76 days before making follow-up telephone calls to insurers to determine why payments had not been made. VHA guidance requires staff to initiate follow-up calls within 30 days of the billing date. To aggressively pursue bills, multiple collection letters should be sent and follow-up calls should be made.

During the review, the Director of Health Plan Management Services agreed that the health care system should comply with VHA policy on MCCF follow-up, but he did not believe this would result in increased collections. However, MCCF officials at other medical facilities have agreed that better follow-up would increase collections. To illustrate, from August to November 2004 we conducted CAP reviews at three other medical facilities that needed to improve MCCF follow-up. The collection rates at these facilities ranged from 26 to 34 percent. MCCF officials at these facilities agreed they could increase collections by at least 5 percent. Based on this, we estimated that the health care system could also increase its collections by at least 5 percent, from 32 to 37 percent. This would provide additional revenue of about \$80,000 ($\$3.2 \text{ million in bills older than 90 days} \times 50 \text{ percent sample result} \times 5 \text{ percent increase in collections} = \$80,000$).

Clinical Documentation Not Adequate. MCCF staff cancelled 1,230 bills during the 6-month period June–November 2004. Of these, 1,157 (value = \$298,822, or 94 percent of the bills) were cancelled because attending physicians did not provide sufficient medical record documentation, such as progress notes. We reviewed 30 bills (value = \$77,930) that had been cancelled because of insufficient documentation and determined that 24 (80 percent) had collection potential. As a result of our review, MCCF staff issued bills totaling \$47,239. Using the health care system's historical collection rate of 32 percent, we estimated that better clinical documentation would have resulted in additional revenue of \$76,498 ($\$298,822 \text{ in bills with insufficient documentation} \times 80 \text{ percent sample result} \times 32 \text{ percent collection rate} = \$76,498$).

In summary, we estimated that MCCF staff could have increased collections by \$156,498 (\$80,000 from aggressively pursuing insurance receivables + \$76,498 from better clinical documentation = \$156,498).

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) insurance bills are pursued more aggressively, and (b) medical records include adequate clinical documentation.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that MCCF staff duties had been restructured to ensure the aggressive pursuit of insurance bills. In addition, by April 15, 2005, a new process will be implemented to ensure clinical documentation is complete and sufficient. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Equipment Accountability – Inventories Should Be Properly Performed and Equipment Inventory Lists Updated

Conditions Needing Improvement. Management needed to improve procedures to properly safeguard and account for nonexpendable equipment (items costing more than \$5,000 with an expected useful life of more than 2 years). VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). FMS staff are responsible for coordinating the EIL inventories, which includes notifying all services when inventories are due and following up on delinquent inventories. Each health care system service is required to perform an inventory of assigned equipment and to update EILs when equipment is transferred or excessed.

As of January 4, 2005, the health care system had 109 EILs listing 2,324 items (total value = \$65.4 million). To determine whether equipment accountability was adequate, we reviewed a judgment sample of 30 equipment items (value = \$2 million) assigned to 10 EILs. We identified three deficiencies that required corrective action.

EILs Not Accurate. The EILs were inaccurate for 10 of the 30 items (33 percent). The EILs had not been updated to reflect the current locations of equipment (six items moved from their previous locations and four items excessed). This problem occurred because FMS staff did not consistently update EILs when equipment was moved or excessed.

Physical Inventories Not Performed. Inventories were long overdue for 5 of the 10 EILs. For example, one Prosthetics Research EIL had not been inventoried since February 2, 2001, and one Cardiology EIL had not been inventoried since April 24, 2001. Overdue inventories occurred because FMS staff did not consistently ask services to perform annual inventories and did not follow up on delinquent inventories. When

physical inventories are not regularly performed, EILs become inaccurate, making it difficult to properly account for and safeguard equipment assets.

Quarterly Spot Checks Not Done. Materiel Management Section staff were not conducting spot checks of inventories as required by VA policy. Quarterly spot checks of completed EIL inventories should be conducted to ensure the accuracy of information and to determine if equipment accountability policies are being followed.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) EILs are updated to accurately reflect the status of all equipment, (b) equipment inventories are performed in accordance with VA policy, and (c) quarterly inventory spot checks are performed.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that in February 2005 a new automated equipment tracking system was purchased to be used for keeping EILs updated. Also, procedures were developed to remind services when inventories are due. Starting in April 2005, quarterly spot checks will be conducted. The improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Procurement of Medical and Prosthetic Supplies – Purchases Need To Comply with VA’s Purchasing Hierarchy

Condition Needing Improvement. Management needed to ensure that medical and prosthetic supplies are purchased in compliance with VA's purchasing hierarchy. VA policy requires medical facilities to purchase supplies according to the hierarchy, which organizes vendors from the most to least preferred sources as follows: national contracts and Blanket Purchase Agreements (BPAs), local BPAs, Federal Supply Schedule (FSS) contracts, local non-FSS contracts, and open market purchases.

To determine if the health care system purchased medical and prosthetic supplies effectively, we selected a judgment sample of 20 supply products and reviewed purchases of these products for the 6-month period July–December 2004. The 20 products included 10 medical products (such as anti-embolism stockings and skin closures) and 10 prosthetic products (such as continuous positive airway pressure machines and nebulizers).

During the review period, the health care system purchased 19 of the 20 products.² For the 19 products, the health care system made 259 purchases at a total cost of \$371,659.

² The 20 products were selected for a planned OIG audit that will focus on the supply purchasing practices of VA medical facilities. These practices will be evaluated as part of selected CAP reviews conducted during FY 2005, and the results will be summarized in an audit report. The sampled product that the health care system did not purchase was regular disposable scalpels.

Seven of the 19 products (37 percent) were not purchased in accordance with the purchasing hierarchy. The health care system made 96 purchases of these 7 products at a total cost of \$66,448. Four of these products should have been purchased from BPAs, and the other three should have been purchased from FSS contracts. If these purchases had been made from the preferred hierarchy sources, the cost would have been \$47,120, a savings of \$19,328 (29 percent of costs for the 7 products and 5 percent of costs for the 19 products).

BPA Waivers Not Approved for Four Products. The health care system purchased four of the seven products from higher priced FSS and open market sources instead of from the available BPAs. Medical facilities that wish to purchase products from sources other than the hierarchy sources must obtain a waiver from the VHA Chief Logistics Office (CLO). The health care system had submitted requests for waivers from using the BPAs for three products: adult diapers, anti-embolism stockings, and adhesive skin closures. However, the CLO had never approved the waivers and FMS did not follow up on the waiver requests. In addition to the three products for which waivers were requested, the health care system purchased six sharps disposal containers from a non-BPA source without requesting a waiver.

The health care system paid \$55,601 for the four products, but would have paid \$38,548 if bought from the BPAs, a savings of \$17,053 (31 percent). CLO officials had no record of the waiver requests and stated that the submitted waivers probably would not have been approved. The following example illustrates the savings if the health care system had purchased skin closures from the BPA source:

Adhesive Skin Closures. The health care system's request for a waiver from using the BPA source for skin closures stated: "We have received several complaints from physicians that neither the one-half inch nor the one-quarter inch skin closures stick to a patient's skin as they are required to." However, before the BPA was established, VHA's Wound Care User Group evaluated the skin closures and found them to be effective. During the review period, the health care system purchased 4,100 skin closures from open market and FSS contract sources at a cost of \$2,503. Using the skin closures available from the BPA would have saved \$1,304 (52 percent).

FSS Contracts Not Used for Three Products. The health care system purchased the other three products from open market sources instead of from FSS contracts. The three products were portable ramps, tub benches, and toilet seats, and the total cost of the open market purchases of these products was \$10,847. If these products had been purchased from FSS contract sources, the cost would have been \$8,572, a savings of \$2,275 (21 percent). The following example illustrates the savings if the health care system had made better use of FSS contracts:

Portable Ramps. Portable ramps can be carried by one person and are intended for use with multiple entrance ways or access areas. During the review period, a 10-foot tri-fold ramp was purchased from an FSS contract source for \$526. This same model ramp was also purchased from two open market sources for \$1,245 and \$930, prices that respectively were \$719 (137 percent) and \$404 (77 percent) higher than FSS prices. A 4-foot suitcase ramp was also available from an FSS contract for \$192. The health care system bought this same ramp from an open market source at a cost of \$590, or \$398 (207 percent) more than the FSS contract. During the review period, the health care system purchased 11 ramps at a total cost of \$4,734. If these ramps had been purchased from the FSS contract, the savings would have been \$1,521 (32 percent).

Hierarchy Not Understood. VHA policy requires that all procurement staff receive purchasing hierarchy training. Twenty-eight of the 31 (90 percent) staff had received the required training. We interviewed a judgment sample of 10 staff to assess their knowledge of the purchasing hierarchy. Five of these employees could not explain the hierarchy and were unaware that national contracts and BPAs were the two most preferred sources.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) procedures are developed to ensure purchasing waiver requests are submitted to VHA and monitored until the CLO's decision is received, (b) supply products are purchased according to the purchasing hierarchy, and (c) refresher training on the purchasing hierarchy is provided to all procurement staff.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that a system will be developed to ensure follow-up of waiver requests and monitoring of purchases for compliance with the purchasing hierarchy. Refresher training on the hierarchy will be provided to staff and documented. The target date for full implementation is July 31, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Quality Management – Resident Supervision and Serious Adverse Outcome Discussions Needed Improvement

Conditions Needing Improvement. The QM program was generally effective, with appropriate review structures in place for 10 of the 12 program activities reviewed. However, resident supervision and serious adverse outcomes discussions needed improvement.

Resident Supervision. Thoracic surgeons needed to better document resident supervision. VHA directives require that the medical record must demonstrate active participation in,

and supervision of, a patient's care by the supervising physician. Our review of medical records for 10 thoracic surgery patients found that the attending surgeons had not entered admission notes or pre-operative notes in any of the 10 patients' records.

Serious Adverse Outcome Discussions. When clinical managers discussed serious adverse outcomes with patients, they needed to notify the patients of their right to file claims, and they needed to document these notifications in the patients' medical records. When such outcomes occur as a result of patient care, VHA policy requires staff to discuss the situations with the patients and to inform them of their rights to file tort or benefits claims. The local policy did not require this notification. During FY 2004, responsible clinicians minimally documented serious adverse outcome discussions with four patients and did not advise these patients of their rights to file claims.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) thoracic surgeons provide and document appropriate resident supervision, (b) clinicians hold and document comprehensive discussions with all patients who experience serious adverse outcomes, and (c) the Acting QM Coordinator revises the local disclosure policy.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that a monitoring process had been implemented to ensure that all resident supervision documentation is complete. By May 2005, a serious adverse outcome policy will be completed, and the local disclosure policy will be revised. The improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Pressure Ulcer Management – Documentation of Skin Assessments and Identification of At-Risk Patients Needed Improvement

Conditions Needing Improvement. Clinicians needed to consistently document patient skin integrity assessments and identify patients at risk for pressure ulcers. Local policies required clinicians to assess all patients at the time of admission and to reassess patients at risk for pressure ulcers every 24 hours. All assessments must be documented in the medical records. Our review of a judgment sample of 10 medical records found that 2 had no documentation of skin assessments at admission and 7 had no documentation of daily reassessments.

In addition, local policy required that nursing communication documents (kardexes) include stickers to identify patients at risk for pressure ulcers and that a schedule for turning the patients be posted at their bedsides. In all 10 cases, nurses had not placed stickers in the nursing communication documents and had not posted turning schedules.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Health Care System Director requires clinicians to: (a) consistently

perform and document patient skin integrity assessments, and (b) identify patients who are at risk for pressure ulcers and follow procedures for preventing pressure ulcers.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that clinicians will be reminded of pressure ulcer prevention and management procedures and compliance will be monitored. The target date for full implementation is April 2005. The improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Colorectal Cancer Management – GI Evaluation Waiting Time Should Be Reduced

Condition Needing Improvement. Clinicians needed to improve the timeliness of colorectal cancer (CRC) diagnosis by reducing the time from GI consultation to patient evaluation. The health care system met the VHA performance measure for colorectal cancer screening, provided timely Surgery and Hematology/Oncology consultative services, developed coordinated interdisciplinary treatment plans, and promptly informed patients of diagnoses and treatment options. However, because of increased workload and limited resources, diagnostic GI procedures were frequently not performed as quickly as intended.

We reviewed a judgment sample of 10 newly diagnosed CRC cases and found that 9 had significant delays. For these nine cases, delays in the time required for GI staff to perform diagnostic procedures ranged from 48 to 305 days, exceeding the GI unit's goal of 37 days. GI staff told us that the demand for GI procedures had exceeded available resources. Our review of workload from FY 2000 through FY 2004 confirmed a steady increase in consults from 3,875 to 5,458 and a subsequent increase in procedures from 3,274 to 3,992. Health care system managers told us that they had reached maximum capacity for the existing space, equipment, and personnel. In April 2005, the health care system will begin a project to renovate and expand the GI clinic to provide more patient treatment capacity.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) improve the waiting time from GI consultation to evaluation, and (b) ensure that the expansion of the GI clinic is completed.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that by May 2005 a program that has reduced waiting times at other VA medical facilities will be implemented at the health care system. Further, space has been vacated to accommodate the expansion of the GI clinic. The improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Emergency Preparedness – Vulnerabilities Needed To Be Addressed

Condition Needing Improvement. The emergency preparedness program was generally effective, but managers needed to develop an action plan that would address vulnerabilities identified by an external review performed in January 2004. The health care system had taken several actions to improve emergency preparedness, including participating in ongoing emergency planning and drills with the community, increasing security since 2001, and training staff.

In January 2004, managers hired a consultant to conduct a physical security assessment of the health care system. The consultant identified three vulnerabilities: the power plant did not have a protective wall barrier, the health care system did not have a perimeter fence, and access to the loading dock was not adequately controlled. At the time of our inspection, health care system managers had not implemented corrective actions in response to these findings. In addition, managers acknowledged that they needed to secure a nursing home air intake vent located at ground level next to a public street.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Health Care System Director develops a plan to address identified emergency preparedness vulnerabilities.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that low-cost options will be explored to correct identified vulnerabilities. The target date for completing this action is April 2005. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Government Purchase Card Program – Purchases Should Be Monitored To Avoid Split Transactions

Condition Needing Improvement. The Purchase Card Coordinator needed to ensure that cardholders did not split transactions to avoid the \$2,500 per purchase limit. VHA policy does not allow cardholders to make purchases above the \$2,500 micro-purchase threshold unless they receive additional procurement training and are issued proper contracting warrants.

During the 14-month period October 2003–November 2004, 136 cardholders made 39,625 purchase transactions totaling about \$26.0 million. Our review of a judgment sample of 50 transactions identified 5 purchases that 3 cardholders had improperly split to circumvent the \$2,500 purchase limit. The 5 purchases totaled \$35,763, and the 3 cardholders had split these purchases into 18 transactions. To illustrate, in October 2004, a group training course that cost \$8,172 was split into 4 transactions and posted over 10 days.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Health Care System Director requires that the Purchase Card Coordinator implement controls to prevent cardholders from splitting purchases.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that by March 2005 the prohibition on split orders will be emphasized to cardholders and monitored for compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Information Technology Security – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed health care system AIS policies and procedures to determine whether controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that health care system staff had received required computer security awareness training and that critical information was backed up on a regular basis. However, we identified two deficiencies that needed corrective action.

Inactive Accounts Not Terminated. Veterans Health Information Systems and Technology Architecture (VistA) access had not been terminated for some inactive users. We reviewed a judgment sample of 20 VistA access accounts and concluded that access should have been terminated for 17 users (12 former employees and 5 current employees who no longer needed access).

Environmental and Physical Security Deficiencies Not Corrected. VHA policy requires computer rooms to have environmental safeguards, such as temperature and humidity controls. The computer room at the Seattle campus did not have an adequate air conditioning system. According to Information Systems Services staff, during the warmer months, computer room temperatures often exceeded the optimal range of mid-to-high 60s. The room temperature reached 78 °F, and server temperatures exceeded 160 °F, which could significantly decrease the life of computer systems. The computer room also did not have the required humidity controls or a water detector to provide early warning of water leaks under the raised flooring. In addition, the room had two physical security deficiencies: there was no motion detector to detect movement in the room after hours, and one exterior door did not have nonremovable hinge pins as required by VA policy.

Recommended Improvement Action 11. We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) promptly terminate VistA accounts for individuals who do not have a continued need for access; and (b) upgrade computer room environmental and physical security by installing adequate air conditioning, humidity controls, a water detector, a motion detector, and nonremovable hinge pins in the exterior door.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported access termination policy and procedures will be developed and implemented by September 2005. Further, plans to address environmental and physical security are expected to be completed by July 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

VISN 20 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 21, 2005

From: Network Director, VISN 20 (10N20)

Subject: Status Report – Combined Assessment Program Review, VA Puget Sound Health Care System, Seattle, Washington.

To: Director, VHA Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the VA Puget Sound Health Care System, Seattle, Washington.
2. If you have any questions regarding this report, please contact David Tostenrude, Health System Specialist at (206) 768-5381.

(original signed by:)

Leslie M. Burger, MD, FACP

Attachments

Health Care System Director Comments

VA PUGET SOUND HEALTH CARE SYSTEM

Response to the Office of Inspector General Combined Assessment Report

Comments and Implement Plan

1. Service Contracts – Preaward Audits Should Be Requested and Contractor Invoices Properly Certified.

Recommended Improvement Action 1: We recommend that the VISN Director ensures that the Health Care System Director requires that: (a) all sole source contracts valued at \$500,000 or more are sent to the OIG for pre-award audits and (b) refresher training is provided to COTR's and Accounting and Fee Section staff on responsibilities and procedures for properly certifying and paying invoices.

Concur with recommended improvement actions.

a. All sole source contracts valued at \$500,000 or more are sent to the OIG for pre-award audits:

Planned Action: We will comply with this policy. Refresher training to all warranted purchasing staff has been completed, **March 17, 2005.**

b. Refresher training is provided to COTRs and Accounting and Fee Section staff on responsibilities and procedures for properly certifying and paying invoices.

Planned Action: COTR refresher training was completed by **February 28, 2005.** Training will be provided for Accounting and Fee Section staff with completion by **June 30, 2005.**

2. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved.

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the Health Care System Director requires, (a) FMS staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply

inventory; (b) PSAS staff to monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetics supply inventory; (c) Engineering Service staff to reduce excess engineering supply inventory and to implement GIP for all engineering supply; (d) and inventory management staff to keep GIP and PIP inventory records current by promptly and accurately posting inventory transactions.

Concur with recommended improvement actions.

a. FMS Staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory:

Planned Action: Inventory Management Staff will increase their screening and reviewing of all item usage rates during the weekly supply ordering process. Manual adjustments to all ordered stock levels will be made at the time orders are generated. Inactive and Long Supply reports that identify excess quantities at 90 day and 180 day increments will be run weekly. Distribution Staff will utilize the stock status data to validate removal of supply items from the inventory. These have been implemented since **February 18, 2005**. The mandated MSPV (Medical Surgical Prime Vendor) program, effective **April 20, 2005** will resolve those areas identified as requiring action. The 30-Day, just in time guideline, will be readily realized, given that our Prime Vendor Source (Cardinal Health) is a local entity.

b. PSAS staff to monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetics supply inventory.

Planned Action: All inventory items will be monitored and PIP stock levels will be adjusted at least quarterly based on usage rates. All medical center staff with prosthetic inventory items located in their area for immediate issue to patients have been informed of the role they must play in this process. This was accomplished **March 4, 2005**. Items which current usage rates will not reduce to prescribed levels within a reasonable time- frame will be transferred to another facility or turned in as excess. To be completed by **June 30, 2005**.

c. Engineering Service staff to reduce excess engineering supply inventory and to implement GIP for all engineering supplies.

Planned Action: Engineering staff will work with Material Management staff to continue the implementation process of identifying and reducing potential excess supply inventory and identifying items for inclusion in the Engineering GIP inventory. The target date for completing the identification, inventory and GIP data entry is **December 31, 2005**.

d. Inventory Management Staff to keep GIP and PIP inventory records current, by promptly and accurately posting inventory transactions:

Planned Action: The Material Management Staff will perform daily follow-ups to assure that all daily transactions are posted. This was initiated **January 31, 2005**.

3. Medical Care Collections Fund – Collection Delays Should Be Reduced and Clinical Documentation Improved.

Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) insurance bills are pursued more aggressively and (b) medical records include adequate clinical documentation.

Concur with recommended improvement actions.

a. Insurance bills are pursued more aggressively:

Planned Action: The MCCR Accounts Receivable Section has implemented a new procedure to ensure timely follow-up. (Timely follow-up was not accomplished during the time period sampled by the Audit due to several vacancies in the Account Receivable Section.) The average days from the date the bill is generated to payment for the inpatient claims in the sample is 32 days. Puget Sound has re-programmed its AR staff duties to ensure that follow-up calls will be made at the 45th day if the claim has not been paid and posted, and every 30 days thereafter. (The Audit Team Manager contacted VACO Revenue Office staff who agreed that calls

need not be made until the claim would normally be paid, and every 30 days thereafter to make prudent use of scarce AR staff resources.)

New Accounts Receivable follow-up procedure implemented **February 1, 2005**.

b. Medical records include adequate clinical documentation.

Planned Action: The MCCR Section and Health Information Management Section of Information Support Services is developing a systematic process to ensure that documentation is completed and sufficient for coding purposes for all billable encounters. The target date for the new process to be in place is **April 15, 2005**, and the results of the new process will be measured for 6 months to ensure that it is effective. The results of this effort will be reported to the Facility Compliance Steering Committee.

4. Equipment Accountability – Inventories Should Be Properly Performed and Equipment Inventory Lists Updated.

Recommended Improvement Action 4: We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) EILs are updated to accurately reflect the status of all equipment, (b) equipment inventories are performed in accordance with VA policy, and (c) quarterly inventory spot checks are performed.

Concur with Recommended Improvement Actions.

a. EILs are updated to accurately reflect the status of all equipment:

Planned Action: A new automated equipment tracking system was brought on line, **February 22, 2005**. We anticipate, that this new system will greatly enhance our ability to accurately maintain, the Equipment status of all of our 109 EILs.

b. Equipment inventories are performed in accordance with VA policy:

Planned Action: Services have been reminded, that it is their responsibility, to perform the required inventory of all their assigned equipment, completed **February 2, 2005**. We have instituted a reminder system for services that do not complete the required inventory as assigned. If service line continues to fail to complete the assignment, this will be reported to Health Care System Director.

c. Quarterly Inventory Spot Checks are performed:

Planned Action: Starting **April 1, 2005**, the Equipment Management Staff will begin quarterly 5 percent random spot check. It will include those inventories conducted during the current quarter. The EILs to be spot-checked are those inventories conducted between **January 1, 2005**, and **March 31, 2005**. Each spot check will be documented, and will determine the calendar date for the next inventory.

5. Procurement of Medical and Prosthetic Supplies – Purchases Need To Comply with VA’s Purchasing Hierarchy

Recommended Improvement Action 5: We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) procedures are developed to ensure purchasing waiver requests are submitted to VHA and monitored until the CLO’s decision is received, (b) supply products are purchased according to the purchasing hierarchy, and (c) refresher training on the purchasing hierarchy is provided to all procurement staff.

Concur with recommended improvement actions

a. Procedures are developed to ensure purchasing waiver requests are submitted to VHA and monitored until the CLO’s decision is received:

Planned Actions: We are working with the VISN 20 CLO to establish a system to ensure we follow up on waiver requests. The target completion date for implementation of this system is **July 31, 2005**.

b. Supply products are purchased according to the purchasing hierarchy

Planned Action: Standard operating procedures are being updated and will include a monitoring component. Monthly monitor will be used for prosthetic supply items beginning **March 2005**. Sample size will be adjusted based on findings.

c. Refresher training on the purchasing hierarchy is provided to all procurement staff.

Planned Action: Refresher training will be provided to all prosthetic staff and documented by in-service meetings at least quarterly. Refresher training on the purchasing hierarchy will be provided to all procurement staff, this will be completed by **June 30, 2005**.

6. Quality Management – Resident Supervision and Serious Adverse Outcomes Discussion Need Improvement.

Recommended Improvement Action 6: We recommend that the VISN Director require that the Health Care System Director requires that: (a) Thoracic surgeons provide and document appropriate resident supervision, (b) Clinicians hold and document comprehensive discussions with all patients who experience serious adverse outcomes, and (c) The acting QM coordinator revises the local disclosure policy.

Concur with recommended improvement actions.

a. Resident Supervision: Thoracic surgeons needed to better document requirements for resident supervision. VHA directives require that the medical record must demonstrate active participation in, and supervision of, a patient's care by the supervising physician. Our review of medical records for 10 thoracic surgery patients found that the attending surgeons, had not entered admission notes or pre-operative notes in any of the 10 patients' records.

Planned Actions:

(1) We have required that the involved surgeon update all non-documented reports and summaries. As of **March 9, 2005**, the documentation is 100 percent complete and current.

(2) Beginning in **March 1, 2005**, we have implemented a monitoring process for all surgery for ensuring that documentation is complete and current. Privileges will be removed as a last resort if compliance is not met.

b. Clinicians hold and document comprehensive discussions with all patients who experience serious adverse outcomes.

Planned Action: The Disclosure of Medical Errors policy will be completed in May 2005. An agenda item on for the **May 5, 2005** Clinical Executive Board will be to review the new policy and specifically outline procedures for disclosure of serious adverse outcomes.

c. The acting QM coordinator revises the local disclosure policy.

Planned Actions: Facility policy will be revised by **May 2005**.

7. Pressure Ulcer Management – Documentation of Skin Assessments and Identification of At-Risk Patients Needed Improvement.

Recommendation Improvement Actions 7: We recommend that the VISN Director ensure that the Health Care System Director requires clinicians to: (a) consistently perform and document patient skin integrity assessments and (b) identify patients who are at risk for pressure ulcers and follow procedures for preventing pressure ulcers.

a. Consistently perform and document patient skin integrity assessments.

Concur with recommended improvement actions.

Planned Action: The CAP report and recommendations will be the focus of the next Nursing Leadership Committee Meeting on April 7, 2005. The Skin Team will be apprised of the CAP Report and recommendations at their next meeting on April 12, 2005. Recommended improvement actions, written by the CAP Assessment Team, will be implemented as follows:

(1) Nursing Leadership Committee Meeting will serve to disseminate the CAP findings and recommendations to all nursing leaders, especially Nurse Managers and supervisors, who in turn will review findings and recommendations with their staff. Nurse Managers and supervisors will monitor the process for prevention and management of impaired skin integrity, and ensure that staff is consistent with the performance of assessments and daily reassessments with accompanying documentation.

(2) Nursing Quality Management will continue to monitor and provide monthly reports on pressure sores.

(3) The Skin Team will address the areas of needed improvement by providing education to bedside caregivers. This education will be ongoing. The skin information on the Nursing Web site will be reviewed and updated by June 2005.

b. Identify patients who are at risk for pressure ulcers and follow procedures for preventing pressure ulcers.

Concur with recommended improvement actions.

Planned Action: The Nurse Managers will reinforce the criteria with their staff for identifying at-risk patients and monitor the process for preventing pressure ulcers. The skin team will reinforce this expectation with education to bedside providers. The policy will be reinforced, and monthly monitoring will continue.

8. Colorectal Cancer Management – GI Evaluation Waiting Time Should Be Reduced.

Recommendation Improvement Action 8: We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) improve the waiting time from GI consultation to evaluation and (b) ensure that the expansion of the GI clinic is completed.

Concur with recommended improvement actions.

a. Improve the waiting time from GI consultation to evaluation.

Planned Action: The planned action is to implement Advanced Clinical Access, a program commissioned by VHA from the Institute of Healthcare Improvement to decrease wait time at VA facilities. Dr. Nguyen, the acting chief of GI Section, is a member of both the local Puget Sound ACA Committee and the VISN20 ACA Steering Committee. Implementation is currently underway; ongoing projects include VISN-wide service agreements between GI and primary care to be approved by **May 1, 2005**, and consult templates to be implemented **May 1, 2005**.

The wait time was longer at American Lake than Seattle, reflecting a higher clinical demand / supply ratio. Since **March 1, 2005**, we have been scheduling procedures and consults originating from American Lake at the Seattle campus to balance the workload.

b. Ensure that the expansion of the GI clinic is completed.

Planned Action: Concur. While we agree with the recommendation and have vacated space to accommodate the expansion, the current facility financial situation does not allow implementation at the present time. Will review in FY06.

9. Emergency Preparedness – Vulnerabilities Needed To Be Addressed.

Recommended Improvement Action 9: We recommend that the VISN Director ensure that the Health Care System Director develops a plan to address identified emergency preparedness vulnerabilities.

Concur with recommended improvement actions.

Planned Action: In **January 2004** a Physical Security Pre-Assessment was conducted which provided preliminary observations of a number of potential physical security vulnerabilities at VAPSHCS. The primary finding of this pre-assessment was that VAPSHCS should receive a comprehensive physical security assessment which would better define these vulnerabilities and formulate priorities, options and costs to address them. This comprehensive assessment process is being centrally managed and has not

yet been funded or scheduled. In the meantime, we are exploring low cost options to provide enhanced security. It is anticipated these options and costs will be available for review by **April 15, 2005**.

10. Government Purchase Card Program – Purchases Should Be Monitored To Avoid Split Transactions.

Recommendation Improvement Action 10: We recommend that the VISN Director ensure that the Healthcare System Director requires that the Purchase Card Coordinator implement controls to prevent cardholders from splitting purchases.

Concur with recommended improvement actions.

Planned Actions: The three specific cardholders mentioned have been directly notified and advised of the purchase limits. By **March 11, 2005** we will send out a blanket notice to all cardholders about the prohibition regarding split orders. We emphasize this requirement in our bi-annual training of cardholders but will give it more emphasis in future sessions. We have advised our auditors to pay closer attention to this prohibition in all future reviews. We have provided additional training to our auditors on identifying split transactions.

11. Information Technology Security – Controls Should Be Strengthened.

Recommended Improvement Action 11: We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) promptly terminate VistA accounts for individuals who do not have a continued need for access and (b) upgrade computer room environmental and physical security by installing adequate air conditioning, humidity controls, a water detector, a motion detector, and nonremovable hinge pins in the exterior door.

Concur with recommended improvement actions.

- a. Promptly terminate VistA accounts for individuals who do not have a continued need for access:

Planned Actions:

- (1) Create clear policy and procedures as to how and when to properly terminate users, implement by **September 2005**.
 - (2) Reduce the number of inactive but not terminated accounts to no more than 5 percent of the total user accounts, this is completed.
 - (3) Identify clearly the core group of exception accounts, with documented requests and approvals for these accounts by **September 2005**.
 - (4) Develop and implement automated tools that will help the ADPACs and CACs keep accounts clean and properly terminated inactive accounts by **September 2005**.
- b.** Upgrade computer room environmental and physical security by installing adequate air conditioning, humidity controls, a water detector, a motion detector, and nonremovable hinge pins in the exterior door.

Planned Action: The improvements to the HVAC system, to include addressing air conditioning and humidity control, are near 100 percent complete for the design phase. The replacement HVAC equipment is anticipated to be in operation by **June 30, 2005**. VAPSHCS developed NRM project to correct the remaining deficiencies in the computer and switch rooms. Assuming funding is approved in the FY 06 NRM program, it is anticipated that the work will be complete by **July 31, 2006**. In the interim the hinges were replaced with tamper proof hinges on February 23, 2005 and a water monitoring system has been specified and is intended to be in place by **May 30, 2005**.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
1	Better use of funds by requesting IG preaward audits.	\$1,377,716
2	Better use of funds by reducing excess medical (\$418,842) and prosthetic (\$104,762) supply inventories.	523,604
3	Better use of funds by improving MCCF procedures.	<u>156,498</u>
	Total	\$2,057,818

OIG Contact and Staff Acknowledgments

OIG Contact	David Sumrall (206) 220-6654
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Acknowledgments	Randall Alley Myra Taylor Julie Watrous Daisy Arugay Gary Abe Donna Giroux Barry Johnson Theresa Kwiecinski Vishala Sridhar Melinda Toom John Tryboski Orlando Velasquez Wilma Wong James Eckrich
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