Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the VA Medical Center St. Cloud, Minnesota

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.

- Conduct fraud and integrity awareness training for facility staff.

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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Contents

Executive Summary

Introduction

During the week of October 27–31, 2003, the OIG conducted a CAP review of the VA Medical Center St. Cloud, MN, which is part of Veterans Integrated Service Network (VISN) 23. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness briefings to 151 medical center employees.

Results of Review

The QM program was effective, Research Service staff complied with requirements of the Veterans Health Administration's (VHA's) national stand down of human subject research, and part-time physician time and attendance was effectively monitored. In addition, the Government purchase card program was effectively managed, unliquidated obligations were properly monitored, and Medical Care Collections Fund (MCCF) procedures were adequate. To improve operations, VISN and medical center management needed to:

- Provide training to and better coordinate with medical center staff when implementing new information technology, and purchase a sufficient number of software licenses.

- Secure sharp instruments, and store medical equipment and oxygen tanks properly.

- Request background investigations and include required security clauses in position descriptions for high-risk positions.

- Review driving records for driving performance, provide and document safe driving training of staff and volunteers who transport patients, and review contract ambulance drivers' records.

- Fully implement the Generic Inventory Package (GIP), improve its accuracy and the accuracy of Prosthetics Inventory Package data, reduce supply inventory levels, improve controls over supply distribution, and conduct periodic physical inventories.

- Provide training to pharmacy and ward personnel on the use of automated controlled substances inventory systems and install a panic alarm in the pharmacy area.

- Improve documentation of contracting actions.

VISN 23 Director Comments

The VISN Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 13-18, for the full text of the Director's comments.) We will

follow up on the planned actions until they are completed. This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. William J. Gerow, Jr., CAP Coordinator, Chicago Audit Operations Division.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in St. Cloud, MN, the medical center is a primary medical and mental health facility that provides inpatient and outpatient health care services. Outpatient care is also provided at community-based outpatient clinics (CBOCs) in Brainerd and Montevideo, MN. The medical center is part of VISN 23 and serves a veteran population of about 422,000 in a primary service area that includes 34 counties in Minnesota and 4 counties in South Dakota.

Programs. The medical center provides acute and long-term psychiatric inpatient care and primary outpatient care. The medical center has 15 psychiatry and 25 psychiatric residential rehabilitation beds. It also operates 228 nursing home and 123 domiciliary beds. Outpatient specialties include urology, ambulatory surgery, audiology, optometry, dentistry, and podiatry. The facility also provides special emphasis programs that include residential substance abuse, post-traumatic stress disorder, a psychiatric residential rehabilitative treatment program (PRRTP), extended care, adult day health care, ventilator care, and other special emphasis programs.

Affiliations and Research. The medical center is not affiliated with a school of medicine but has affiliations with 26 colleges and universities for nursing, pharmacy, psychology, social work, and other education programs.

Resources. In Fiscal Year (FY) 2003, the medical center's expenditures were $70.8 million, about a 3 percent increase from FY 2002 expenditures of $69 million. Medical center staffing through October 2, 2003, was 865 full-time equivalent employees (FTEE), including 24 physician and 246 nursing FTEE.

Workload. In FY 2003 the medical center treated 24,857 unique patients, and in FY 2002 it treated 20,493 unique patients. In FY 2003, the average daily census (ADC) was 10 inpatients, 204 nursing home care unit patients, 93 domiciliary patients, and 29 PRRTP patients. In FY 2002 the ADC was 15 inpatients, 209 nursing home care unit patients, 100 domiciliary patients, and 27 PRRTP patients. Outpatient workload totaled 191,588 visits in FY 2003 and 177,688 visits in FY 2002.

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 services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful 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; met with veteran service organization and union representatives; and reviewed clinical, financial, and administrative records. The review covered the following 15 activities:

Contracting	Medical Care Collections Fund
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Environment of Care	Patient Transportation Services
Government Purchase Card Program	Personal Funds of Patients
Human Subject Research Stand Down Requirements	Quality Management Program
	Supply Inventory Management
Information Technology Purchases	Supply Processing and Distribution
Information Technology Security	Unliquidated Obligations

The review covered medical center operations for FYs 2002, 2003, and 2004 through October 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5–12). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and quality of care. We invited medical center employees to complete an on-line electronic questionnaire, 92 of whom did so. We also interviewed 30 patients. The surveys and interviews indicated high levels of patient and employee satisfaction and did not disclose any significant issues. The questionnaire and interview results were provided to VISN and medical center management.

During the review, we also presented 3 fraud and integrity awareness training sessions that were attended by 151 employees. The training sessions 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

The Quality Management Program Was Effective. The medical center had an effective QM program to monitor and improve the quality of care using national and local performance measures and patient-safety management strategies. Provider specific performance data was appropriately analyzed for the purpose of renewing clinical privileges. Improvement actions recommended by root-cause analysis reviews and administrative boards of investigations were implemented and monitored for effectiveness.

Research Service Staff Complied With Stand Down Requirements. The medical center fully complied with the requirements of VHA's 90-day national stand down of human subject research in 2003. The purpose of the stand down was to ensure that patient rights were protected and that research was conducted in an ethical manner. Reviews of Research Service policies and procedures, Institutional Review Board committee minutes, employee training records, and appropriate databases revealed that the research staff were in compliance with stand down requirements.

Part-Time Physician Time And Attendance Was Effectively Monitored. The medical center employed two part-time physicians. Timekeepers submitted signed attendance records and appointment schedules weekly to the service line manager for review and approval. Fiscal Service staff reviewed the physicians' timecards and appointment schedules each week and initiated appropriate corrections when warranted.

Government Purchase Card Program Was Effectively Managed. Medical center staff complied with VA policy on the use of Government purchase cards. Cardholders and approving officials performed reconciliations and approvals timely, and program controls were adequate.

Unliquidated Obligations Were Properly Monitored. Fiscal Service staff reviewed unliquidated obligations monthly, contacted the appropriate services to determine the continued validity of obligations, and promptly cancelled obligations that were no longer needed.

Medical Care Collections Fund Procedures Were Adequate. MCCF staff accurately identified and coded billable episodes of care. Bills were accurate, accounts receivable were properly established, and collections were timely.

Opportunities for Improvement

Information Technology Purchases – Training and Coordination Related to New IT Purchases Needed To Be Improved

Conditions Needing Improvement. Controls over information technology (IT) purchases were adequate. VISN managers selected IT projects that supported organizational goals and objectives, and the medical center had an accurate inventory of its existing systems, applications, and IT purchases. However, medical center and VISN management could improve training for IT users and provide better coordination related to new IT purchases.

Training. VISN 23 officials purchased and installed two telecommunications-related systems at the medical center for which users did not receive adequate training. As a result, the systems were under-utilized.

The VISN installed a Business Communication Manager (BCM) and Public Branch Exchange (PBX) system on October 28, 2002. One feature, called an Auto Call Distribution Group, automatically routes inbound telephone calls to a predefined directory of call groups. The benefits of the feature included enhanced operations, reduced telephone costs, improved performance, and improved customer service. However, these benefits were not fully realized at the medical center's two CBOCs because CBOC staff did not receive adequate training on configuring the BCM and PBX components to communicate with each other.

An Interactive Voice Recognition telephone answering system was installed in June 2003. The system provided a 24-hour automated patient prescription refill request line. Patients could use the service without employee intervention and without leaving their homes. Pharmacy Service staff did not receive training on how to program the system to provide clear instructions and menu options for callers. This resulted in low utilization of the service.

Coordination. In two instances, VISN 23 staff did not adequately coordinate with medical center staff concerning software they installed. VISN 23 staff installed software Version 22 of the Clinical Patient Record System in September 2003, which changed the display of information and removed several alert notifications. Medical center clinics experienced slow system responses that temporarily hindered clinic operations. Only after the medical center's computer help desk was flooded with telephone calls did VISN staff inform medical center Information Resources Management (IRM) staff about the software installation.

In August 2003, VISN officials purchased and installed new terminal emulation software for the medical center's computer terminal server for use with 452 newly purchased terminals. However, the software was not compatible with the server, which rendered all 452 terminals inoperable. To maintain operability, medical center staff re-installed older terminal emulation software. However, in doing so they violated the software maker's licensing agreement. The medical center owned only 75 licenses for the software but used it to run 452 terminals.

Recommended Improvement Actions 1. We recommended that the VISN Director ensure that: (a) using staff are provided with training when new information technology is implemented; and (b) VISN staff coordinate with medical center staff when implementing information technology changes and the Medical Center Director purchases the appropriate number of licenses for terminal emulation software used on computer terminals.

The VISN Director agreed with the recommendations and reported that, although there existed a structure to support the training of staff, processes will be developed to identify, train, and track the training of individual users impacted by IT initiatives. Complete implementation is anticipated by June 1, 2004. In addition, the VISN Chief Information Officer has implemented a project management program for new IT initiatives, which will identify owners and users of new initiatives and involve them in their implementation. A plan is being developed to deploy terminal emulation software that will meet licensing requirements. The target implementation date is May 1, 2004. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care – Safety and Environmental Deficiencies Needed To Be Corrected

Conditions Needing Improvement. The Dementia Patient Care Unit provided safe, open areas for patients. A fenced garden area adjacent to the dementia unit allowed patients to enjoy the outdoors. Plants in the garden were non-toxic, sidewalks were flat and even, and benches were ideally placed for patients to rest and relax. However, service line supervisors needed to ensure that sharp instruments were secured, excess medical equipment was removed from a patient care room, and oxygen tanks were properly stored.

VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors. We inspected inpatient and outpatient areas, the patient dining room, and Supply Processing and Distribution (SPD) areas. The SPD areas were neat and orderly with proper climate and environment control. Service line supervisors generally maintained a clean environment and took actions to correct identified deficiencies.

Unsecured Sharp Instruments. There were unsecured sharp instruments (for example, scissors and scalpel blades) in outpatient examination rooms. Sharp instruments needed to be secured to prevent accidental or purposeful injury to patients, employees, and visitors.

Inappropriately Stored Medical Equipment. Excess medical equipment (for example, blood pressure machines and thermometers) was stored in the antechamber of a patient's bedroom. Medical center staff in the area stated that the equipment was not used for the care of the patient occupying the room. Nursing managers stated that the antechamber was often used to store excess equipment due to a lack of space on the ward. Patient rooms should be free of equipment that is not used for patient care.

Additionally, empty and full oxygen tanks were stored together. VHA guidelines recommend that used equipment be stored separately from clean equipment to prevent cross-contamination.

Empty oxygen tanks should be stored in a soiled utility area or returned for cleaning and reissue. New or full oxygen tanks should be kept in a clean storage area.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) sharp instruments are secured; and (b) medical equipment and oxygen tanks are stored appropriately.

The VISN Director agreed with the recommendations and reported that staff have been remedially trained in the necessity of securing sharp instruments and that reinforcement training and surveillance will continue. Remedial training was also conducted on the need to separate empty and full oxygen tanks, and as of January 13, 2004, the tanks had been separated. In addition, as of January 22, 2004, appropriate space for the storage of oxygen tanks had been found and the tanks moved. The improvement plans are acceptable, and we consider the issues resolved.

Information Technology Security – Certain Security Controls Needed To Be Improved

Conditions Needing Improvement. IT security controls were adequate in the areas of security awareness training, contingency planning, user access, risk assessment, virus protection, password controls, computer room security, and backup and recovery. The Information Security Officer (ISO) proficiently performed system audits. However, there were two areas where managers could improve IT security and comply with VA policies.

Background Investigations. Background investigations for certain medical center positions did not match assigned sensitivity level designations. VA policy requires that personnel assigned to high-risk positions have full background investigations covering a 10-year period. Six employees in positions designated as high risk did not have the required type of background investigation completed. During the CAP review, Human Resources Management (HRM) staff took action to request the proper background investigations for the six employees.

Position Descriptions. VA policy requires that employees holding high-risk positions have an information security clause included in their position descriptions (PDs) to describe their specific security responsibilities. The ISO and 11 other positions in IRM were designated high-risk. The PDs for the ISO and 10 of the 11 IRM employees did not contain the required security clause. During the CAP review, HRM staff and the ISO took action to include the required security clause in the position descriptions.

Recommended Improvement Actions 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) request appropriate background investigations for employees in high-risk positions; and (b) include the appropriate information security clause in PDs for high-risk positions.

The VISN Director agreed with the recommendations and reported that requests will be submitted to upgrade background investigations to Critical-Sensitive as required. In addition, the medical center ISO and HRM staff were working with VISN staff to incorporate the standard

security clause into position descriptions for Critical-Sensitive positions. These actions should be completed by June 30, 2004. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Patient Transportation Services – Internal Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center employees, volunteers, and contract drivers routinely transported patients for a variety of reasons and activities. To help ensure the safety of patients, VA regulations require that supervisory staff review the driving records of all persons who transport patients on behalf of VA. The purpose of the reviews is to ensure that drivers do not represent an inappropriate level of risk for VA patients because of a history of accidents, moving violations, or motor vehicle-related convictions. VA regulations also require that employees and volunteers are provided with safe driving training annually.

Driver Record Verifications. Personnel records did not document that the driving records of three employee motor vehicle operators (MVOs) were reviewed before they were hired and reviewed again at least once every 4 years. The driving records of three volunteer drivers were reviewed in October 2003, but available documentation did not support that earlier reviews had been completed.

Driving Training. Personnel records did not show that three employee MVOs had completed required annual safe driving training. In addition, there was no documentation to show that the three volunteer drivers had completed this training.

Contract Driver Competency. The medical center had contracts with four community companies to transport patients. The contracts required that these companies maintain records of their employees' training, character, and physical capabilities for performing the duties of ambulance drivers or attendants. Although the contracts required that these records be made available to the medical center upon request, medical center contracting staff had never requested drivers' records from the transport companies.

Recommended Improvement Actions 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) driving records for employee and volunteer drivers are reviewed for safe driving history; (b) employees and volunteers who transport patients receive annual safe driving training and the training is documented; and c) contracting staff request and periodically review records of training, character, and physical capabilities of drivers from contract transport companies.

The VISN Director agreed with the recommendations and reported that, effective October 1, 2003, the medical center requires a Minnesota Department of Motor Vehicles report on all candidates for volunteer and employee positions who may transport patients and submits information to the National Driver Registry upon their assignment and every 3 years thereafter. Annual driving safety training will be provided to both volunteers and employees. In addition, by April 20, 2004, a request will be made to current transportation contractors to provide training and competency records of drivers and will be made again at contract renewal, annually, or as

required. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. VHA policy establishes a goal that medical centers carry no more than a 30-day supply of medical, prosthetic, and engineering supplies. To assist medical centers in meeting this goal, VHA policy requires the use of GIP for certain types of supplies and recommends similar systems for other types of supplies. Inventory managers can use GIP and similar systems to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and conduct physical inventories.

In FY 2003, the medical center spent $1.6 million on medical, prosthetic, and engineering supplies. Support Services staff used GIP to manage medical supplies and the Prosthetics Inventory Package (PIP) to manage prosthetics supplies. To determine the accuracy of the quantities and value of supplies reported in the two systems and to test the reasonableness of inventory levels, we reviewed inventory data and judgmentally sampled supply line items from each system. Five conditions needed corrective actions. The medical center needed to fully implement GIP, improve the accuracy of GIP and PIP data, reduce inventory levels, improve controls over supply distribution, and conduct periodic physical inventories.

Use of GIP. Facilities Management Service (FMS) staff used GIP to manage supply inventories in the housekeeping, paint, and grounds and transportation shops. However, FMS staff did not use GIP or any other inventory control system to manage engineering supplies used in other shops, such as the electrical, carpentry, and plumbing shops. During the CAP review, the Chief of FMS provided a plan that would implement GIP throughout FMS.

Reported Stock Quantities and Value. Information in GIP and PIP did not accurately reflect supply levels on hand and overstated the value of medical and prosthetic supplies. Support Services staff did not properly record transactions in GIP or PIP when removing items from inventory. Inaccuracies in inventory data can lead to unexpected shortages of needed supplies or premature orders for replenishment of supplies.

As of October 30, 2003, GIP reported that there were 2,788 units of 11 judgmentally sampled medical supply line items having a value of $8,480. However, a physical inventory disclosed that there were actually only 2,400 units of the 11 line items on hand with a value of $3,782. GIP overstated the quantity of the sampled items on hand by 388 units and their value by $4,698 (124 percent).

As of October 27, 2003, PIP reported that there were 74 units of 10 judgmentally sampled prosthetic supply line items having a value of $5,812. A physical inventory disclosed that there were actually 70 units of the 10 line items on hand with a value of $5,452. PIP overstated the quantity of the sampled items on hand by four units and their value by $360 (7 percent).

Excess Inventory. Support Services and FMS staff needed to monitor supply usage rates and adjust stock levels to achieve the 30-day supply goal. Five of 11 medical supply line items judgmentally sampled on October 30, 2003, had inventory levels ranging from 66 days to over 2 years. The value of the supplies that exceeded 30 days was $1,421, or 38 percent of the $3,782 stock on hand. Eight of the 10 prosthetic supply line items judgmentally sampled on October 27, 2003, had inventory levels ranging from 50 days to almost 2 years. The value of the supplies that exceeded 30 days was $4,147, or 76 percent of the $5,452 stock on hand. Nine of the 10 engineering supply line items judgmentally sampled on October 29, 2003, had inventory levels ranging from 69 days to about 2 years.[1] The estimated value of the supplies that exceeded 30 days was $4,761, or 83 percent of the $5,721 stock on hand. Excess supply inventories tie up medical center funds that could be put to other uses.

Inventory Distribution Controls. As of October 27, 2003, PIP reported that Support Services staff maintained a prosthetics inventory of 283 line items valued at $43,462. These supplies were not stored in a centralized location, but in several different areas of the medical center. Other medical center staff had authorized access to these storage areas and could remove items from inventory without the knowledge of Support Services staff. This made it difficult for Support Services staff to control and record in PIP the distribution of prosthetics supplies, which would contribute to inaccuracies in PIP.

Physical Inventory. VHA policy requires that a complete inventory of all medical supplies be conducted annually. Support Services staff had not performed a complete inventory of medical supplies in the preceding 2 fiscal years.

Recommended Improvement Actions 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) fully implement GIP, (b) improve the accuracy of GIP and PIP by recording all transactions into those systems; (c) reduce inventory levels to the 30-day supply goal by monitoring GIP and PIP supply usage rates; (d) strengthen prosthetics inventory distribution controls by limiting access through centralization of the storage location; and (e) conduct annual physical inventories of medical supplies.

The VISN Director agreed with the recommendations and reported that GIP would be fully implemented by March 2004. The Support Services performance improvement plan has been modified to include the improvement of GIP and PIP accuracy. Data on GIP and PIP accuracy will be collected monthly until variances are within 1 percent. Feedback will be provided to supervisors and managers responsible for inventory control. Data will be collected monthly until 99 percent of inventory is at a 30-day supply level, and monthly feedback will be provided to supervisors responsible for purchasing inventory controlled by GIP and PIP. As of January 23, 2004, most prosthetics supply inventory had been centralized to an area under the control of prosthetics purchasing staff. By September 30, 2004, the VISN Director expects that additional space will be available, that use of scanning equipment will be implemented, and that additional controls for certain prosthetics stocks will be in place. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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[1] Three of the 10 line items were managed by GIP. FMS staff managed the remainder manually, and usage rates for those were based on FMS staff estimates.

Controlled Substances Accountability – Certain Security and Control Procedures Needed To Be Improved

Conditions Needing Improvement. Accountability and security of controlled substances in Pharmacy Service were generally effective. Physical security was adequate, and the number of staff accessing the pharmacy vault was within permitted limits. Pharmacy Service staff maintained a perpetual inventory of controlled substances and conducted required Drug Enforcement Administration biennial inventories. Pharmacy Service staff had also conducted required quarterly destructions of expired and unusable drugs. Controlled substances inspectors used appropriate inspection procedures. However, two conditions needed corrective actions.

<u>Training of Pharmacy and Ward Personnel</u>. An OIG-caused unannounced inspection of controlled substances on October 29, 2003, showed that certain pharmacy and ward personnel were not adequately trained on accessing the Controlled Substance Balance Report (CSBR) in the automated Pharmacy Production system (PPS). During an inspection, balances recorded in CSBR are matched to the physical counts of controlled substances on hand. We accompanied inspectors to the pharmacy vault and 11 wards and observed 3 instances where the inspectors needed to assist Pharmacy Service and ward staff in accessing CSBR data before the physical counts could begin. In addition, the controlled substances inspector on one ward identified a torn codeine tablet package that needed to be disposed of. However, the ward nurse did not know how to record the disposition in PPS. The inspector had to record the disposition of the drug.

<u>Controlled Substances Security</u>. Although overall physical security of the Pharmacy Service area was adequate, there was no panic alarm to call medical center police to the area. In addition, during the OIG-caused controlled substances inspection, an inspector found one 2mg vial of lorazepam stored in an unlocked refrigerator on a patient care ward. Controlled substances need to be secured in locked containers.

Suggested Improvement Actions 1. We suggested that the VISN Director ensure that the Medical Center Director takes action to: (a) provide Pharmacy Service and ward personnel with training on accessing CSBR and inputting disposition information into PPS, and (b) install a panic alarm in the Pharmacy Service area and secure controlled substances stored in refrigerators.

The VISN Director agreed with the suggestions and reported that by February 15, 2004, learning needs would be identified and training customized to meet these needs. In addition, by June 1, 2004, a panic alarm would be installed in the Pharmacy Service area and appropriate storage units acquired for ward supplies of controlled substances. The improvement plans are acceptable, and we consider the issues resolved.

Contracting – Contract File Documentation Needed To Be Improved

Condition Needing Improvement. Contract prices and terms were generally supported and reasonable. However, contracting staff needed to improve contract file documentation. To determine if contracting staff had complied with Federal Acquisition Regulations (FAR) in

soliciting and awarding contracts on behalf of the medical center, we reviewed eight medical services acquisition contracts with an estimated total annual value of $850,000. We also reviewed two selling agreements with a total annual value of $49,000 to determine if they complied with VHA policies that control the sale of health care resources.

The FAR requires that contracting files contain complete records of contracting actions and price negotiations, including evaluations of past contractor performance for contracts in excess of $100,000. Files should also contain acquisition plans, evidence of notifications to unsuccessful bidders or offerors, records of closeout procedures, and records of technical evaluations of bids or offers. VHA policy requires that selling agreement files contain certifications by the Medical Center Director that the sale of the medical services will not interfere with priority services for veterans.

All eight medical services acquisition contract files lacked some required documentation. None of the contract files contained acquisition plans. Medical center representatives evaluated offers using a scoring process that took into account cost, past performance, and technical specifications. Although the eight contract files contained summaries of the final scores, none explained how the factors were evaluated other than the factor for cost. Two contract files did not document that unsuccessful bidders had been notified of awards to the successful bidders. One contract file (for a closed out contract) did not document that excess funds had been de-obligated and that a review had been performed of the contractor's final invoice.

Neither of the two selling agreement files contained the required certifications from the Medical Center Director that the sale of the medical services would not interfere with priority services for veterans.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director take action to include required documents in contract files.

The VISN Director agreed with the suggestion and reported that by March 17, 2004, required documents will be identified and checklists developed to ensure that all required elements are in contract files. The improvement plan is acceptable, and we consider the issue resolved.

VISN 23 Director Comments

**Department of
Veterans Affairs**   **Memorandum**

Date: January 23, 2003

From: Director, VA Midwest Health Care Network (10N23)

Subject: Combined Assessment Program Review, VA Medical Center, St. Cloud, MN

To: Office of Inspector General
Thru: VHA Management Review Service (10B5)

1. The St. Cloud VA Medical Center carefully reviewed the suggestions and recommendations from their October 2003 Office of Inspector General Combined Assessment program review. I concur with the findings and recommendations in the attached memorandum.

2. Network 23 appreciates the opportunity to have the Office of Inspector General visit one of our facilities. What they have seen and heard from the dedicated staff at the St. Cloud VA Medical Center emphasizes their continued commitment to the high level of care for our Network veterans.

ROBERT A. PETZEL, MD

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:

<u>**OIG Recommendation(s)**</u>

Recommended Improvement Action 1(a): We recommend that the VISN Director ensures that using staff are provided with training when new information technology is implemented.

Concur   **Target Completion Date:** June 1, 2004

There is an existing structure to support training of staff from the project manager down to the end user. Problematic issues with this process include timely communication and the provision of individual instruction to the end user. The existing structure consists of the following:
1) Initiative identified
2) Process owners identified
3) Implementation plan formulated by IT staff
4) Training provided to ADPACs/CACs by IT staff or vendor
5) Training provided by ADPACs/CACs to end-users.
Classrooms are available to conduct training. Training initiatives are identified as part of the project plan. These initiatives must be carried out by the identified process owners to effectively train the end users. This will entail involvement by identified individuals from each of the services impacted by the supported initiative. IRM staff will track required training issues with the planned initiative through project management. Local site ISO will formulate a plan to track training within service lines for individual users by March 1, 2004. The training plan will be submitted to the VISN CIO.

Recommended Improvement Action 1(b): We recommend that the VISN Director ensures that VISN staff coordinate with medical center staff when implementing information technology changes and the Medical Center Director purchases licenses for terminal emulation software used on computer terminals.

Concur   **Target Completion Date:** May 1, 2004

The VISN CIO is responsible for licensure purchases for terminal emulation software. The VISN CIO has implemented the utilization of project management for all new initiatives involving IT. Project managers from integrated IRM staff are assigned to each authorized initiative. There is a requirement that a Management Definition Guide (MDG) must be submitted for each initiative by the sponsoring facility. From this process owners are identified and an implementation plan is created. As the plan is developed, specific tasks are assigned to the project team members. Each facility is represented by team members who have responsibilities to update key facility staff on

planned dates of implementation, costs, changes and impact to the facility. In addition, the assigned IRM project managers plan future reviews with IRM Chiefs so that local IRM management can be made aware of planned initiatives. This is part of the organizational structure being proposed by the VISN CIO to management & the Union. Compliance with these processes should ensure appropriate coordination with each site on any IT initiative.

The VISN CIO has discussed and reviewed the licensing issue of terminal emulation software with the IRM Technical Services section. A plan is being formalized to deploy software that was procured in the past that provides the required number of licenses. This deployment involves loading the software on the Terminal Servers that are accessed by thin client devices. All existing personal computers (PCs) currently have a legal copy of either the new or the old emulation software loaded on them.

Recommended Improvement Action 2(a): We recommend that the VISN Director ensure that the Medical Center Director requires that sharp instruments are secured.

Concur   **Target Completion Date:** Completed
                                                                            December 20, 2003

Provisions are in place to ensure all sharps are secured throughout the medical center. Staff have been remedially trained in the necessity of securing sharps. Reinforcement of the training and surveillance will continue.

Recommended Improvement Action 2(b): We recommend that the VISN Director ensure that medical equipment and oxygen tanks are stored appropriately.

Concur   **Target Completion Date:** January 13, 2004

Current policy and infrastructure does provide for separate storage of empty and full oxygen tanks. Remedial training was done and a visual inspection of all storage facilities was performed and we have confirmed that they are now separate. Reinforcement of the training and surveillance will continue.

Concur   **Target Completion Date:** January 22, 2004

Facilities Management Service (FMS) and Extended Care and Rehabilitation (EC&R) have met to develop a plan to provide appropriate storage of medical equipment. Appropriate corrective action has been identified. The work has been completed and medical equipment has been relocated.

Recommended Improvement Action 3(a): We recommend that the VISN Director ensure that the Medical Center Director takes action to request appropriate background investigation for high-risk positions.

Concur   **Target Completion Date:** June 30, 2004

Human Resources requested from OPM and Office of Security and Law Enforcement the status of the pending Non-Critical Sensitive Security Background investigations. Requests will be submitted to upgrade the background checks to Critical-Sensitive as required. Target date is based on OPM's ability to complete the background checks.

Recommended Improvement Action 3(b): We recommend that the VISN Director ensure that the Medical Center Director takes action to include appropriate information security clauses in position descriptions for high risk positions.

Concur   **Target Completion Date:** June 30, 2004

The facility ISO and Human Resources are working with the VISN ISO, VISN CIO, local and VISN supervisors and the union to incorporate standard security clauses into position descriptions of Critical-Sensitive positions. The security statements will be added to PDs of VISN and facility staff residing at St. Cloud. The VISN CIO will ensure these clauses are incorporated into the position descriptions of VISN staff by the target date.

Recommended Improvement Action 4(a): We recommend that the VISN Director ensure that the Medical Center Director requires that driving records for employee and volunteer drivers are reviewed for driving performance.

Concur   **Target Completion Date:** Ongoing

Volunteers: A MN Department of Motor Vehicle report is required prior to consideration as a volunteer driver (implemented 10/01/03). Upon acceptance as a volunteer driver, information is submitted to the National Driver Registry and re-submitted every three years thereafter.

Employees: Positions requiring the routine transportation of veterans will require review by the MN Department of Motor Vehicle report prior to assignment to the position. Information on all employees in such positions will be submitted to the National Driver Registry upon assignment and every three years thereafter.

Recommended Improvement Action 4(b): We recommend that the VISN Director ensure that the Medical Center Director requires that employees and volunteers who transport patients receive annual safe driving training and the training is documented.

Concur   **Target Completion Date**: September 30, 2004

Volunteers: Annual driver safety training will be conducted and documented.

Employees: Annual driver safety training will be conducted and documented.

Recommended Improvement Action 4(c): We recommend that the VISN Director ensure that the Medical Center Director requires that contracting staff request and periodically review training and competency records of drivers from contract transport companies.

Concur   **Target Completion Date:** April 20, 2004

The current contracts allow us to request and review the training and competency records of drivers. A request for the records of the current contractors will be initiated. In the future this will be done upon renewal of the contract, annually, or as needed.

Recommended Improvement Action 5(a): We recommend that the VISN Director ensure that the Medical Center Director take action to fully implement Generic Inventory Package (GIP).

Concur   **Target Completion Date:** March 31, 2004

GIP will be fully implemented and operational in all mandatory areas by the end of March 2004. Updating the VistA Item Master file for all areas serviced by GIP will be completed by February 2004. Storage sites will be prepared (e.g., organized and labeled) by March 2004. In areas where GIP is not currently functional, staff will receive training by the end of March 2004. A feedback mechanism regarding progress toward performance improvement goals will be provided monthly to the staff involved in GIP and PIP, their supervisors, and Product Line Managers. All staff involved in GIP will receive refresher training at least annually.

Recommended Improvement Action 5(b): We recommend that the VISN Director ensure that the Medical Center Director take action to improve the accuracy of GIP and Prosthetic Inventory Package (PIP) data by recording all transactions into those systems.

Concur   **Target Completion Date:** March 31, 2004

Performance improvement plan for Support Services has been modified to include this element. GIP and PIP data will be collected monthly until variance between actual inventory and theoretical inventory is within 1% or less.

Monthly feedback will be provided to supervisors and managers responsible for the purchasing of inventory items in every area where PIP and GIP are operational. Progress towards PIP goals will be reported in the Durable Medical Equipment Committee minutes. Progress toward GIP goals will be reported in the Commodity Standards Committee Minutes.

Recommended Improvement Action 5(c): We recommend that the VISN Director ensure that the Medical Center Director take action to reduce inventory levels to the 30-day supply goal by monitoring GIP and PIP supply usage rates.

Concur   **Target Completion Date:** March 31, 2004

Data will be collected monthly until 99% of the value and quantity of inventory is at a 30 day level or less. Monthly feedback will be provided regularly to supervisors and managers responsible for the purchasing of inventory items in every area where PIP and GIP are operational. Progress towards PIP goals will be reported in the Durable Medical Equipment Committee Minutes. Progress towards GIP goals will be reported in the Commodity Standards Committee Minutes.

Recommended Improvement Action 5(d): We recommend that the VISN Director ensure that the Medical Center Director take action to strengthen prosthetics inventory distribution controls through centralization of the storage locations.

Concur   **Target Completion Date:** September 30, 2004

Most of the prosthetic inventory has already been centralized to an area under the sole control of prosthetic purchasing staff. Additional space is needed in the prosthetic storage area and a request for space will be submitted. In addition, scanning equipment needs to be installed and activated. Additional controls are necessary for Rehabilitation Clinic areas, CBOC Clinics and St. Cloud

Ambulatory Care Clinics. This will be achieved by establishing the following: inventory level, restocking schedules, and delivery standards. Progress toward goals will be reported to the Durable Medical Equipment Committee.

Recommended Improvement Action 5(e): We recommend that the VISN Director ensure that the Medical Center Director take action to conduct annual physical inventories of medical supplies.

Concur   **Target Completion Date:** Completed.
                                                               December 2003

A complete physical inventory was done during December 2003. A physical inventory is now scheduled to be completed quarterly. Results will be reported in the Commodity Standards Committee minutes.

OIG Suggestion(s)

Suggested Improvement Action 1(a): We recommend that the VISN Director ensure that the Medical Center Director take action to provide pharmacy and ward personnel with training on accessing Controlled Substance Balance Report (CSBR) data and inputting disposition information into the Pharmacy Production System (PPS).

Concur   **Target Completion Date:** February 15, 2004

Learning needs will be identified and training will be customized to meet those needs.

Suggested Improvement Action 1(b): We suggest that the VISN Director ensure that the Medical Center Director takes action to install a panic alarm in the pharmacy area and secure controlled substances stored in refrigerator.

Concur   **Target Completion Date:** June 1, 2004

The Facility Development Planning (FDP) meeting held on 1/12/04 approved and prioritized the installation of three panic alarms in the pharmacy area.

Securing controlled substances in refrigerators was discussed at the November Nursing Professional Practice Council meeting. Appropriate storage units are being reviewed for selection and installation.

Suggested Improvement Action 2: We suggest that the VISN Director ensure that the Medical Center Director take action to include required documents in contract files.

Concur   **Target Completion Date:** March 17, 2004

Required contract documents will be identified and appropriate checklists will be developed to ensure all required elements are available in the contract files.

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5c	Reduction of excess supply inventory would permit better use of medical center funds.	$10,329
	Total	$10,329

OIG Contact and Staff Acknowledgements

OIG Contact	William Gerow (708) 202-2344
Acknowledgements	Verena Briley-Hudson John Brooks Paula Chapman Larry Chinn Terrye Hall Freddie Howell Ray Jurkiewicz Dana Martin Katherine Owens Cherie Palmer John Pawlik Raymond Vasil Ora Dell Young

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