Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the Carl T. Hayden VA Medical Center Phoenix, Arizona

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VA Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's effort to ensure that high quality health care is 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 on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

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Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Carl T. Hayden VA Medical Center (VAMC). The purpose of the review was to evaluate selected VAMC operations, focusing on patient care quality management (QM) and financial and administrative management controls. During the review we also provided Fraud and Integrity Awareness training for about 200 VAMC employees.

The Carl T. Hayden VAMC is a 285-bed tertiary care facility, providing a full range of medical, surgical, psychiatric, and nursing home care services. The VAMC's Fiscal Year (FY) 2000 budget is $176.6 million and staffing is about 1,707 employees. In FY 1999, the VAMC provided care to 40,401 unique patients.

Patient Care Quality Management. VAMC management had created an environment that supported quality patient care and performance improvement. The VAMC had a comprehensive QM program that effectively coordinated patient care activities and that provided strong oversight of the quality of care. We made two recommendations to improve patient care management. First, stronger controls were needed to ensure that problematic bedside glucose test results were referred for laboratory analysis as required by VAMC policy. Second, management needed to address several issues and concerns pertaining to the patient care environment, staffing, and medical records.

Financial and Administrative Management Controls. The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, we recommended that the VAMC: (a) reduce excess supply inventories; (b) strengthen timekeeping for part-time surgeons; (c) perform required annual equipment inventories; (d) improve collection of vendor accounts receivable; (e) include expired drugs in controlled substances inspections; and (f) ensure that signed means test forms are obtained from patients.

Medical Center Director Comments. The VAMC Director concurred with the recommendations and provided acceptable implementation plans. (See Appendix III for the full text of the Director's comments.) We consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

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

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Introduction

Carl T. Hayden VA Medical Center

The Carl T. Hayden VA Medical Center is a highly affiliated facility providing tertiary medical, surgical, psychiatric, and nursing home care. Outpatient care is provided at the VAMC and at primary care extension clinics located in Sun City, Mesa, and Show Low, Arizona. The VAMC is one of six medical centers in Veterans Integrated Service Network (VISN) 18. The VAMC's primary service area includes metropolitan Phoenix and the south-central Arizona counties of Maricopa and Gila. The veteran population in the service area is 265,000.

Programs. The VAMC has 181 acute care beds and 104 nursing home beds and operates a wide range of specialty medical programs such as gastroenterology and nephrology. In Fiscal Year (FY) 1999, the VAMC's medical research program had 122 active projects and a budget of about $755,000. The VAMC serves as a referral hospital for other VISN 18 facilities and provides specialized medical services for the Northern Arizona VA Health Care System based in Prescott, Arizona. In October 1998, an ambulatory care addition was completed, providing more space for outpatient clinic, and for Pharmacy, Laboratory, Audiology, and Dental Services.

Affiliations. The VAMC is affiliated with the University of Arizona School of Medicine and with several multidisciplinary Phoenix Independent Resident Programs and supports 73 medical resident positions in 25 training programs. Clinical training rotations are also provided for 231 medical students and 261 nursing students.

Resources. In FY 1999, VAMC medical care expenditures totaled about $149.0 million. The FY 2000 budget is $176.6 million, 17.7 percent more than the FY 1999 budget. As of January 2000, staffing totaled 1,706.6 full-time equivalent employees (FTEE) and included 118.7 physician FTEE and 477.2 nursing FTEE.

Workload. In FY 1999, the VAMC treated 40,401 unique patients, a 6.0 percent increase from FY 1998. Inpatient care was provided to 8,851 patients, and the inpatient average daily census, including nursing home patients, was 213.9. The outpatient care workload was 379,000 visits, and outpatient care was provided to 31,550 outpatients as well as to most inpatients.

Objectives and Scope of CAP Review

The purposes of the CAP review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to VAMC employees.

Patient Care Quality Management Review. Office of Healthcare Inspections staff reviewed selected clinical activities, with the objectives of evaluating the effectiveness of Quality Management and patient care management. The QM program is a set of integrated processes designed to monitor and improve the quality of patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering

patient care and includes patient-provider interactions, coordination between care providers, and ensuring staff competence. To meet the review objectives, we inspected patient care areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. As part of the review, we used questionnaires and interviews to survey employee and patient opinions and perceptions about quality of care, timeliness of service, and satisfaction with care received. The review covered the following 13 clinical operations and monitoring functions:

- Acute Medical-Surgical Units
- Primary Care Clinics
- Specialty Care Clinics
- Nursing Home Care Unit
- Radiology
- Infection Control
- Risk Management/Patient Safety
- Pharmacy
- Behavioral Health Care
- Nutrition and Food Service
- Pathology and Laboratory
- Utilization Management
- External Oversight

Financial and Administrative Management Review. Office of Audit staff reviewed selected financial and administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, to prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed management and employees, and reviewed pertinent administrative, financial, and clinical records. The review covered the following 19 activities and management controls:

- Service Contracts
- Nursing Home Care Contracts
- Purchase Card Program
- Fee Basis Care Program
- Agent Cashier Operations
- Unliquidated Obligations
- Information Technology Security
- Supply Inventory Management
- Part-Time Physician Timekeeping
- Equipment Accountability
- Accounts Receivable
- Controlled Substances Inspections
- Pharmacy Security
- Medical Care Cost Fund
- Accounting Controls
- Information Technology Acquisition
- Employee Travel
- Construction Planning
- Equipment Acquisition

Fraud and Integrity Awareness Training. Office of Investigations special agents conducted four Fraud and Integrity Awareness briefings for VAMC employees. About 200 employees attended these briefings, which 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.

Scope of Review. The CAP review covered VAMC operations for FY 1999 and FY 2000 through January 2000. The review was done in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

Results and Recommendations

Patient Care Quality Management

Patient Care Quality Management Was Generally Effective

VAMC management had created an environment that supported quality patient care and performance improvement. As the following examples illustrate, we identified a number of noteworthy achievements in the QM program and in patient care management.

The QM Program Was Comprehensive. The VAMC had a comprehensive QM program that provided strong oversight of the quality of care. The QM program included national and local performance measures, risk management, utilization management, occurrence screening, and peer review. The Executive Performance Improvement Council (EPIC) met regularly to review QM data and to recommend action as necessary. Each service line made a periodic presentation on its important quality of care issues. The EPIC was in the process of developing five major initiatives: determining essential programs and services; improving the effectiveness of the organization; enhancing employee productivity; becoming the employer of choice; and maximizing resources.

In June 1999, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performed its triennial accreditation survey of the VAMC. JCAHO did not identify any serious deficiencies in any of the VAMC's acute care activities and made only one recommendation, which pertained to improving patient education documentation in the Long-Term Care Program.

Ongoing quality of care monitors included patient safety/risk management, infection control, restraint use, medication use, operative procedures, blood products use, staff competence, and medical record documentation. We reviewed eight administrative investigations and one root cause analysis and found the processes to be sound and the conclusions and corrective actions to be relevant.

The Patient Representative Program Improved Service to Patients. Two Patient Representatives were available to veterans and family members who had concerns and complaints. The most common concerns pertained to lack of patient involvement in care decisions, disagreements about treatment plans, and lack of confidence in individual care providers. To supplement the Patient Representatives and to further assist patients with their concerns, patient advocates had been appointed in each service line.

Care Was Effectively Coordinated. The VAMC had created registered nurse planner positions to assist with coordination of care in the inpatient areas. Managers planned to initiate a similar position for outpatient care. Pharmacists in ambulatory clinics and inpatient units also assisted with continuity of care and patient education. A discharge education center had been implemented to assist patients in the transition from inpatient care to home or another setting. Our inpatient survey data indicated that staff spent sufficient time explaining changes in treatment plans. Although, as mentioned above, the VAMC's Patient Representatives had

received some complaints about lack of patient involvement in care decisions, our survey indicated that patients felt that they were involved in decisions about their care.

The Primary Care Model Was Efficient. The VAMC's primary care program was initiated more than 5 years ago. Primary care panels were well established, with more than 95 percent of patients assigned to a primary care provider. The new ambulatory care addition allowed for two exam rooms per provider. Our outpatient survey results suggested that the VAMC's primary care model was successful -- 96 percent of patients knew who their primary provider was; 98 percent believed that their primary provider managed their overall care; and 91 percent were seen by the same provider for scheduled primary care visits. Managers had identified an opportunity to improve coordination of care in primary care and had initiated a performance improvement team. The team was in the process of initiating a pilot program with one of the Primary Care Clinics. This pilot program included telephone-linked care, an electronic communication link for care managers, and criteria to identify veterans with complex health conditions who would benefit from care management over the continuum of care.

A Successful Restraint and Seclusion Improvement Project Had Been Completed. In 1998, the VAMC undertook a project to assess its restraint and seclusion process and to make needed improvements. The project team identified several issues, one of which was documentation of orders, progress notes, and monitoring of patient needs while the patient was in restraints or seclusion. The team made a concerted effort to streamline the required documentation, with resulting marked improvement. The team continued to meet and address efforts needed to reduce restraint use throughout the facility.

The Latex Allergy Program Was a "Best Practice." The VAMC's program for protecting patients and employees who are allergic to latex was a best practice that could be shared with other VAMCs. Nurse Managers on each patient care unit had easy access to carts stocked with latex-free products, so these products were readily available to be given to employees or patients who were allergic to latex. The carts were painted lavender to differentiate them from other carts. The rooms of patients with latex allergy were clearly marked with signs on the door and above the patients' beds. Special latex-free surgical kits were available upon request. We commended the VAMC for their approach to this important health concern.

Concerns About Surgical and Anesthesia Services Were Being Addressed. In March 1999, in response to a complaint, the Veterans Health Administration's (VHA's) Office of the Medical Inspector (OMI) reviewed the operations of the VAMC's Surgical and Anesthesia Services. As of February 2000, the VAMC was in the process of preparing a response to the OMI report. We reviewed the OMI report and discussed it with VAMC management. Management expressed disagreement with some of OMI's conclusions. However, over the past 2 years they had initiated a number of improvements in Surgical and Anesthesia activities, including: continuing a formal search process to name a permanent Chief for Surgical Service; contracting for anesthesiologist services; initiating anesthesia staff morbidity and mortality (M&M) discussions; including certified registered nurse anesthetists (CRNAs) in case reviews and staff meetings; appointing a lead CRNA to oversee the performance of the other CRNAs; inviting anesthesiologists and CRNAs to surgical M&M conferences as appropriate; initiating a prospective study of airway complications; and implementing post-anesthesia use of blanket warmers and blood warmers.

Recommendations for Improving Patient Care Management

Bedside Glucose Testing -- Problematic Results Should Be Analyzed

The VAMC had a policy that allowed for bedside glucose monitoring (a form of ancillary testing) for diabetic patients who needed frequent glucose checks. The policy required that nurses and physicians respond to glucose monitoring values that were so far outside the defined range as to be problematic for patient care. When a value was outside the defined range, the nurse was required to notify the physician, who was then required to have a sample of the patient's blood sent to the laboratory for glucose analysis. We reviewed January 2000 test results and found three cases with results outside the defined range. Laboratory analyses had not been done for these three cases. The ancillary coordinator acknowledged that VAMC policy had not been followed for the three cases and that training and stronger oversight were needed to ensure that staff comply with glucose monitoring policy.

Recommendation 1. The VAMC Director should ensure that (a) responsible employees receive refresher training on glucose monitoring requirements and (b) controls are implemented to enforce compliance with glucose monitoring policy.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that both the refresher training and the implementation of compliance controls would be completed by July 2000.

Office of Inspector General Comments. The comments and implementation plan were acceptable and we consider the issue to be resolved.

Patient Care Environment, Staffing, and Medical Records -- Various Issues and Concerns Should Be Addressed

During the review we noted several issues and concerns that did not require individual recommendations but that collectively warranted management attention. Management agreed to evaluate these issues and to take corrective action as necessary.

Patient Care Environment. We were generally impressed with the cleanliness of the VAMC and did not note any significant sanitation deficiencies. However, several employees and patients expressed concerns about cleanliness and suggested that the VAMC was not always as clean as it was during our review. Management acknowledged that keeping all areas of the VAMC clean was sometimes a problem, largely because of the high turnover in housekeeping positions and the difficulty of filling vacancies. Management had been giving ongoing attention to this problem.

We noted that carts and gurneys were parked in the hallways throughout the medical center. Cart clutter was especially evident on the inpatient units, presenting a potential safety hazard. This problem was largely caused by ongoing inpatient ward renovation projects, which had temporarily reduced storage space. Management agreed that alternative storage space needed to

be found and that hallways should be kept clear except for carts that are in active use and that can be easily moved in an emergency.

Handicapped Accessibility. Several patients complained that the rear door of the new ambulatory care addition did not open automatically and therefore presented an accessibility problem for some disabled patients. The door was especially a problem because it was the entrance nearest the handicapped parking lot. The door met Americans With Disabilities Act standards, but an automatic door would better serve patients. Management agreed to assess the feasibility of installing an automatic door.

Patient Access to Veterans Services Officers. The offices of the Veterans Services Officers (VSOs) are located in an outbuilding away from the patient care areas of the main hospital building. This made it difficult for some patients to have access to the VSOs. One VSO stated that when he was in the main hospital seeing patients he had to lock his office. This meant that other patients who visited his office had to wait outside until he returned. Management recognized that ideally the VSOs should be located in the main hospital, but this had been difficult because of space shortages resulting from ongoing and planned construction. Management agreed to explore options for relocating the VSOs closer to patient care areas.

Staffing Issues Raised by Employees. Several managers and employees indicated a need for more staff and a need to achieve more with existing employees. Only 52 percent of employees who responded to our survey stated that there was sufficient staff to provide care to all patients who needed it. Many nursing employees in direct patient care positions felt overwhelmed by their workloads, or more significantly, believed that their ability to attend to patient needs was, at times, inadequate. Management considered nurse recruiting to be the VAMC's most important staffing challenge. The VAMC was aggressively recruiting to fill vacant nurse positions and was utilizing nurses from temporary staff registries.

The results of our inpatient survey indicated that basic needs were being met despite the nurse staffing problem -- 89 percent of inpatients felt that call lights were answered within 5 minutes, and 89 percent of inpatients who experienced significant pain felt that they received adequate medication or treatment to relieve the pain. To ensure the best utilization of staff time, nurse managers should continue assessing work practices and eliminating inefficiencies. For example, nursing staff complained that the admission assessment process was too cumbersome and duplicative. We referred nurse managers to a successful integrated admission assessment process used at VAMC Long Beach.

Inpatient Mental Health Continued Stay Reviews. The utilization management program included reviews of all scheduled admissions, and Nurse Care Planners performed continued stay reviews on the inpatient medical/surgical units. However, continued stay reviews were not done on the Mental Health inpatient unit. Management agreed with our suggestion that Mental Health and Behavioral Science managers begin performing these reviews and using the resulting data to ensure optimal bed utilization.

Patient and Employee Survey Results. As part of the CAP review we obtained perceptions from employees and patients through the use of questionnaires and interviews. In the employee questionnaire, we covered topics including job satisfaction, staffing, and quality of care. In the

patient questionnaires, we covered topics such as timeliness, access, and courtesy. A total of 425 employees and 161 patients completed questionnaires. The overall results of the surveys were very positive. The specific results listed below may be of interest to management in its efforts to improve customer service and staff morale. The full survey data was sent to VAMC management.

- VHA policy requires that each inpatient have one physician who is in charge of his/her care. Only 72 percent of the inpatients surveyed stated that one specific physician was in charge of their care.
- More than one-third of outpatients responded that waiting times for scheduled appointments and prescriptions generally exceeded the 30 minutes standard in effect at the time of our review.
- Employees expressed dissatisfaction with the recognition and awards process. Fifty percent of employees surveyed perceived that sometimes incompetence was encouraged and rewarded.
- Sixty-three percent of the employees who responded rated the VAMC's quality of care as excellent or very good and 80 percent would recommend the VAMC to an eligible friend or family member.

Medical Record Review Results. We reviewed records on two focused clinical activities: management of very low glucose levels (2 records) and management of low albumin in long-term care patients (30 records). These two topics were selected for study on all FY 2000 CAP reviews and may be included in a multi-facility report. We reviewed the assessment and management of patients once the low albumin value was obtained and noted three deficiencies in medical record documentation – only 36 percent of the records documented the adequacy of the patient's diet; only 61 percent documented actual food intake; and only 53 percent documented physician follow-up of dietician recommendations.

Recommendation 2. The VAMC Director should ensure that the issues and concerns discussed above are reviewed and that corrective action is taken as warranted and feasible.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that corrective action on several issues had begun or had been completed. For example, in April 2000 the VAMC implemented new procedures for continued stay reviews in the Mental Health unit, and by October 2000 the VAMC will request project funding to replace the ambulatory care addition door with an automatically opening door.

Office of Inspector General Comments. The comments and implementation plans were acceptable and we consider the issues to be resolved.

Financial and Administrative Management

Management Controls Were Generally Effective

VAMC management had established a positive internal control environment, the financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. As illustrated by the following examples, we found no deficiencies in several of the activities reviewed.

Service Contracts Were Properly Negotiated, Reasonably Priced, and Well-Monitored. As of February 2000, the VAMC had 38 large nonclinical service contracts (value greater than $50,000) and 29 clinical service contracts (excluding community nursing home care contracts). The total value of these contracts was $12.5 million. We reviewed the files pertaining to 10 contracts with a total value of $5.6 million, and we interviewed responsible contracting officers and contracting officer technical representatives (COTRs). The contract files contained good documentation of the contracting process and included price negotiation memorandums and other required information. Contract prices were reasonable and decisions to select other than the lowest bidders were well-justified and documented. COTRs were effectively monitoring contractor performance.

Nursing Home Contracts Were Properly Awarded and Inspections Were Thorough. As of February 2000, the VAMC had 11 locally awarded community nursing home care contracts with a total value of $814,000. We reviewed the files for all 11 contracts and found that they were well-organized and contained all required documentation. Contract prices were generally based on VA's benchmark of the Medicaid rate plus 15 percent. Special care rates higher than the benchmark had been properly approved by VHA Central Office. VAMC staff had conducted annual nursing home inspections on schedule. The inspections were thorough, and deficiencies found by inspections were followed up until corrected. The COTR was properly monitoring contractor performance.

Purchase Card Transactions Were Promptly Reconciled and Approved. The VAMC had 93 employees who were authorized to use purchase cards. These employees held a total of 132 cards. Purchase card transactions were reviewed by 37 approving officials. During the 6-month period August 1999 through January 2000, the VAMC had 7,503 purchase card transactions totaling $3.2 million. Transaction reconciliations and approvals were performed promptly, with about 94 percent of transactions reconciled by cardholders within 5 days as required and about 99 percent of transactions approved by approving officials within 14 days as required. To assess the quality of purchase card training, we reviewed training material and interviewed the Purchase Card Coordinator and several cardholders. The training material was informative and complete. In addition to the initial training for all new cardholders, there were opportunities for additional or corrective training. Cardholders expressed satisfaction with the training and with the administration of the purchase card program.

Fee Basis Care Was Properly Administered and Costs Were Controlled. The fee basis care program was operating effectively. We reviewed records pertaining to a judgment sample of

veterans who received fee basis care and found that the veterans were eligible for the care and that the care had been properly authorized. The VAMC was using VA's Prospective Payment System software to pay fee-basis bills, which ensured that payments were at or below benchmark Medicare rates. The VAMC had taken actions to control fee basis costs. To illustrate, before FY 1999 the VAMC sent certain cardiac care patients to VAMC Tucson, which had the clinical capability needed to care for these patients. In FY 1999, VAMC Tucson's workload increased to the point that Phoenix patients could no longer be accepted. As a result, the VAMC paid a private provider about $900,000 for fee basis cardiac care. To try to reduce this cost, in March 2000 the VAMC issued a solicitation for offers to establish a contract for cardiology services.

Agent Cashier Operations Were Sound. Our review of Agent Cashier operations found no deficiencies. We requested and observed an unannounced audit of the Agent Cashier. VAMC staff conducted the audit properly. The audit found no overages or shortages in the Agent Cashier's funds. We analyzed recent cash disbursements and concluded that the amount of the cash advance was appropriate. The combinations to the Agent Cashier's and the alternate Cashier's safes had been properly secured. Agent Cashier unannounced audits were generally performed every 90 days as required.

Information Technology Security Was Effective. The Automated Information System (AIS) security controls that we tested effectively protected the integrity and confidentiality of data. Procedures, such as the forced change of passwords every 90 days and the deactivation of access when employees are terminated, were in place to control and monitor access to automated databases and local area network applications. Physical security for computer rooms and equipment was adequate. The VAMC had developed a comprehensive AIS contingency plan to reduce the impact of disruptions in service and to quickly resume normal operations.

Recommendations for Improving Management Controls

Supply Inventory Management -- Excess Inventory Should Be Reduced

We evaluated the management of medical, prosthetic, pharmacy, and engineering supply inventories to determine if controls were adequate to prevent the build-up of excess inventory. VAMC services should maintain inventory levels that meet current operating needs. Inventories above those levels should be avoided so that funds are not tied up in excess inventory. Current needs generally can be met by maintaining inventories at no more than a 30-day supply. For pharmacy supplies, current needs can be met by maintaining a 10-day supply because the prime vendor can usually deliver pharmaceuticals within 1 day of ordering. In FY 1999, the VAMC spent $15.1 million on medical, prosthetic, pharmacy, and engineering supplies.

We reviewed inventory management practices in the Supply Processing and Distribution (SPD) Section, in the warehouse, and in Prosthetics and Sensory Aids, Pharmacy, and Engineering Services. We found that many of the inventory management practices used by these activities were sound. However, there was still significant excess inventory. We estimated that the value of medical and prosthetic supply inventories was $732,000 and that the value of excess inventory (more than 30 days supply) was $487,000, or 66.5 percent of the total value. Pharmacy and Engineering Services did not maintain inventory records. Because of this, we could not estimate

the value of pharmaceutical and engineering supply inventories or the amount of inventory that exceeded current needs.

Medical Supplies. SPD used VA's automated inventory management system, the Generic Inventory Package (GIP), to control medical supply inventories. SPD was using some good inventory management practices, such as performing physical inventories, ordering supplies frequently, and properly setting reorder points. SPD had set a 30-day inventory standard. However, SPD had not consistently used normal stock levels to determine reorder quantities. As a result, there had been a build-up of excess inventory for some supply items. We reviewed 10 high cost items and found that 6 had inventory levels that exceeded current needs. Two of these items had excess inventory because normal stock levels had not been used to determine reorder quantities. Both of these items had inventory exceeding a 1-year supply. The other four items had excess inventory because supply managers had overestimated Y2K contingency requirements. At the time of our review the VAMC should have had no more than a 45-day supply of any of these four items. Instead, inventory levels for the four items ranged from 51 to 183 days. SPD maintained an inventory of 1,293 supply items valued at $467,500. By analyzing SPD inventory data and reviewing our sample of 10 supply items, we estimated that the value of SPD inventory exceeding current needs was $348,000 (74.4 percent of the total value).

In addition to the medical supplies stocked in SPD, the supply warehouse maintained an inventory of medical supplies with an estimated value of $150,000. We reviewed inventory levels for a sample of 10 warehouse items and found that for all 10 items SPD inventories were sufficient to meet current needs and that the warehouse inventory of these items was excess. The VAMC supply manager agreed that the warehouse inventory should be reviewed and that items stocked by SPD should be eliminated from the warehouse. Using the warehouse GIP data, we determined that the value of excess medical supplies stored in the warehouse was $122,000 (81.3 percent of the total value).

Prosthetic Supplies. Prosthetics and Sensory Aids Service had established a 30-day supply standard and used the Prosthetics Inventory Package (PIP) automated system to control inventory. PIP allows inventory managers to set reorder points, but does not allow them to set normal stock levels. As a result, purchasing agents used their judgment and experience to determine reorder quantities. Our review of inventory levels and purchasing patterns for a sample of 10 supply items found that for 4 items purchasing agents had established reorder points which minimized stock on hand. For the other six items, purchasing agents ordered several months' supply, resulting in excess inventory. Four of the six items had inventory levels higher than a 30-day supply and the other two items had levels above a 60-day supply. Prosthetics and Sensory Aids Service maintained an inventory of 531 items valued at $114,000. By analyzing PIP data and the results of our sample review, we estimated that the value of prosthetic inventory exceeding current needs was $17,300 (15.2 percent of the total value).

Pharmaceutical Supplies. Pharmaceutical inventory levels were significantly lower than inventories of other types of supplies because of the efficiency of the prime vendor's supply order system and next-day delivery service. Although Pharmacy Service's inventory control system was not automated, supply managers were using good inventory management practices, such as establishing normal stock levels and monitoring and ordering supplies daily. However, written inventory records and usage data were not available, and supply managers had to reply

on experience and on judgmental estimates of usage to determine when and how much to order. Our review of 10 sample items found that inventory levels for 7 of the 10 items were below the 10-day standard and that levels for the other 3 items were between 10 and 20 days. Pharmacy supply managers agreed that normal stock levels for the three items could be reduced to less than a 10-day supply.

Engineering Supplies. Engineering Service did not use an automated inventory system and did not have any written inventory records to manage supply inventories. The absence of an inventory system prevented the service from using basic inventory controls such as establishing normal stock levels, analyzing usage patterns to determine optimum order quantities, and conducting periodic physical inventories. Instead, supply managers had to rely on their experience and on informal estimates of usage to determine when and how much to order. The lack of written inventory records caused engineering supply managers to purchase supplies that exceeded current needs. We reviewed the quantities on hand and usage rates for a judgment sample of 10 engineering supply items. All 10 items had stock on hand exceeding a 30-day supply. Five of the 10 items had inventory levels exceeding a 180-day supply.

Recommendation 3. The VAMC Director should ensure that: (a) automated inventory controls are effectively used to reduce supply inventories to levels consistent with current needs, and (b) warehouse inventories do not include medical supplies stocked by SPD.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that the VAMC had begun action to reduce supply inventory levels. The VAMC would continue to reduce Y2K contingency supplies and had begun implementing GIP and other controls to reduce inventories of medical, prosthetics, pharmacy, and engineering supplies. The target date for completing most of these actions is June 30, 2000.

Office of Inspector General Comments. The comments and implementation plans were acceptable and we consider the issues to be resolved.

Part-Time Physician Timekeeping -- Controls on Part-Time Surgeon Time and Attendance Should Be Strengthened

Part-time physicians are physicians hired to work less than the normal 40-hour duty week. These physicians are hired to work in $1/8^{th}$ duty time increments, with a $1/8^{th}$ increment equaling 5 hours of weekly work time. Timekeepers are responsible for completing timecards to show the part-time physician's assigned tour of duty, the actual hours worked, and any charges to leave (VA Manual MP-6, Part V, Supp. 2.2, 102.03). Part-time physicians are required to work their tours of duty, and timekeepers are required to ensure that timecards accurately reflect the hours physicians are present for duty.

To evaluate part-time physician timekeeping controls, we tried to locate 15 physicians during their tours of duty. Of the 15 physicians, 9 were assigned to Surgical Service and 6 were assigned to other services, such as Medicine and Ambulatory Care. When we checked, all six nonsurgeon physicians and four of the nine surgeons were on duty or on approved leave. However, the other five surgeons were not on duty or leave. Neither the Chief of Surgical Service nor the Surgical Administrative Officer knew where the surgeons were.

All five of these surgeons had private medical practices in the community. They told us that they routinely left the VAMC and went to their practices when the VAMC did not have work for them during their assigned tours. The Chief of Surgery acknowledged that this was a common occurrence. The Surgical Service timekeeper told us that she had been instructed to record the part-time surgeons as present during their assigned tours regardless of whether they were actually at the VAMC.

The frequent absence of the part-time surgeons indicated that their appointment levels may have been too high. To determine if the appointment levels of the five surgeons were in line with their workloads, we reviewed operating room (OR) logs, clinic schedules, and other workload records for the 3-month period November 1999 through January 2000. These records indicated that workloads for four of the five surgeons did not support their appointment levels, as illustrated by the following example:

> A surgeon had a 6/8^{ths} appointment (30 hours per week). During the 3-month review period he should have been on duty for 368 hours. The workload records showed that he was actually on duty for only 191 hours, or 52 percent of the required duty time (33 hours performing OR duties, 117 hours for scheduled clinics, and 41 hours for other duties). The surgeon's assigned tour of duty showed that he should have been at the VAMC every Monday, Tuesday, and Thursday from 8:00 a.m. to noon and every Wednesday and Friday from 7:00 a.m. to 3:30 p.m. (for a total of 29 scheduled hours per week). However, he was actually at the VAMC every Wednesday from 7:00 a.m. to 3:30 p.m. for surgery and every Friday from 7:00 a.m. to 3:30 p.m. for a clinic (for a total of 17 hours of actual work time). He told us that he went to his private practice if there was no work at his Friday clinic, so his actual on-duty clinic hours were probably less than the 117 hours in scheduled clinic time.

Surgical Service management stated that they believed that the part-time surgeons worked additional hours that were not accounted for in workload records. However, management could not provide any evidence of this additional work. Management believed that on-call duty should be included as part of surgeons duty time and that because the surgeons performed on-call duties they should be allowed to leave the VAMC if there was no work for them during their assigned tours. However, this practice is not allowed by VA policy, which states that both full-time and part-time physicians are expected to work their assigned tours and may not receive extra pay for on-call duty (VA Manual MP-5, Part II, Chapter 3, 8a.(1) and b.(2)). In addition, according to the on-call schedule, some of the surgeons, such as the one discussed in the example above, did not have on-call duties.

In our opinion, the VAMC's part-time surgeon timekeeping practices present a risk of improprieties occurring. At the least, there is a risk of the appearance of impropriety -- the appearance that the surgeons are working at their private practices on VA-paid time. To address this issue, the VAMC needs to establish controls to account for any part-time surgeon work that is not shown in existing workload records and to ensure that part-time surgeons are only paid for actual on-duty time. In addition, because the workload records indicate that the appointment levels of some part-time surgeons may be too high, VAMC management should ensure that the surgical workload is analyzed and that all appointments are consistent with workloads.

Recommendation 4. The VAMC Director should ensure that (a) Surgical Service establishes effective controls to account for all part-time surgeon work time and to properly pay part-time surgeons only for actual on-duty time and (b) part-time surgeon appointment levels are adjusted as necessary to be consistent with workloads.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that responsible VAMC managers would review the tours of duty for all part-time surgeons and would make appropriate changes so that the tours more accurately reflected the time spent performing physician duties. The VAMC also planned to implement a flexible work hours schedule for part-time surgeons, develop procedures to better document surgeon time and attendance, obtain surgeon services on a fee basis when appropriate, review part-time surgeon appointment levels each quarter, and make adjustments as necessary. The target date for completing these actions is June 4, 2000.

Office of Inspector General Comments. The comments and implementation plan were acceptable and we consider the issue to be resolved.

Equipment Accountability -- Annual Equipment Inventories Need To Be Done

The VAMC needed to improve procedures for accomplishing annual inventories of nonexpendable equipment (equipment costing more than $5,000 with an expected useful life of more than 1 year). VA policy requires that these inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Materiel Management staff are responsible for coordinating the annual EIL inventories, and the various VAMC services are responsible for performing the inventories of equipment assigned to them.

As of February 2000, the VAMC had 65 EILs listing 1,211 equipment items with a total value of $34.9 million. To determine if equipment inventories had been done on a 1-year schedule, we reviewed inventory records for all 65 EILs. The records showed that only 30 (46.2 percent) of the 65 EILs had been inventoried within the last year. (The value of the equipment on the 30 EILs was $12.1 million, or 34.7 percent of the $34.9 million total equipment value.) The other 35 EILs (53.8 percent) with equipment valued at $22.8 million (65.3 percent of the total value) had not been inventoried for 3 to 5 years. Of these 35 EILs, 19 had not been inventoried in more than 4 years.

The problem of delinquent inventories occurred primarily because some VAMC services did not meet their responsibility to complete the inventories. Acquisitions staff had requested the inventories from the services, but they had not been done. To illustrate, in August 1999, 65 EILs had been sent to the responsible services and inventories requested. As of February 2000, only 4 inventories had been completed.

To determine if equipment on the uninventoried EILs could be adequately accounted for, we reviewed a judgment sample of 30 items from 5 delinquent EILs. We were able to locate 29 of the 30 items. The item we could not find was a $149,000 echocardiograph-image analyzer. VAMC staff believed that this item had been turned in for disposal in 1996.

Based on our review, we do not believe that a significant number of equipment items are missing. However, to ensure that equipment is properly accounted for and to establish an accurate baseline equipment inventory, a 100 percent inventory should be performed before the end of FY 2000.

Recommendation 5. To ensure that equipment is properly accounted for, the VAMC Director should require that all EILs be inventoried by the end of FY 2000.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. The equipment inventories should be completed by July 15, 2000.

Office of Inspector General Comments. The comments and implementation plans were acceptable and we consider the issue to be resolved.

Accounts Receivable -- Delinquent Debts Should Be Pursued

VA policy requires that accounts receivable owed to the VAMC be collected promptly. To ensure that accounts receivable are accurately recorded, each month Finance Department staff should reconcile the General Ledger to subsidiary accounting records showing amounts billed, paid, and owed. In addition, at least once each quarter Finance staff should review the "Verification of General Ledger Balances -- Accounts Receivable" report to identify receivables that are more than 90 days old. These delinquent receivables should be analyzed to determine whether they should be pursued or written off. Receivables that have recovery potential should be aggressively pursued through the use of collection letters, telephone calls, and referrals for enforced collection if necessary.

During our review, Finance staff acknowledged that they had not been consistently performing either the monthly reconciliations or the quarterly reviews. In FY 1999, the reconciliations and reviews had been done only in April and September, and none had been done since September. As a result, further collection efforts were needed on some receivables owed by vendors.

As of December 31, 1999, the VAMC had 60 vendor receivables valued at $186,295. Of these, 44 (73.3 percent) with a value of $30,551 (16.4 percent of the total value) were more than 90 days old. To evaluate the collection potential for these receivables, we reviewed 10 of the larger receivables with a total value of $28,792. Based on discussions with Fiscal Service staff, we concluded that 9 of the 10 receivables (value = $27,450) required more aggressive collection:

- Five receivables needed to be referred for enforced collection. Fiscal Service had sent collection letters to the vendors but had received no responses. The total amount owed on these five receivables was $16,753. Four of the vendors had received duplicate payments from the VAMC and one had been paid in error.

- Additional collection efforts were needed on four receivables owed by health care providers who had sharing arrangements with the VAMC. These four bills had a total value of $10,697 and were from 3 to 5 months old. Fiscal Service had sent collection letters, but had not called the vendors to determine why payment had not been made.

Recommendation 6. To improve the collection of vendor accounts receivable, the VAMC Director should ensure that (a) Fiscal Service establishes effective controls for identifying and pursuing delinquent receivables and (b) the delinquent receivables identified by our review are pursued or written off as required.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that an additional employee had been placed in the Accounting Section so that accounts receivable can be better pursued.

Office of Inspector General Comments. The comments and implementation plans were acceptable and we consider the issue to be resolved.

Controlled Substances Inspections -- Expired Drugs Should Be Included in Inspections and the Pharmacy Vault Door Should Be Kept Shut

VAMCs are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The purpose of these inspections is to ensure that controlled substances are properly accounted for. The inspectors must be VA employees who do not work in the Pharmacy Service. Inspectors should physically count the quantities of controlled substances on hand and reconcile these quantities to perpetual inventory records. We requested and observed an unannounced inspection of selected areas where controlled substances were stored and dispensed. We also reviewed records of the inspections done for the 13-month period January 1999 to January 2000. Both our unannounced inspection and the prior inspections found good accountability for controlled substances.

We noted only one inspection issue -- inspection procedures did not cover excess, outdated, or unusable controlled substances that were stored in the pharmacy vault until they could be destroyed. VHA policy requires that inspections include these drugs (VHA Handbook 1108.2). To ensure independent oversight of stored drugs and to comply with VHA policy, these drugs should be included in the monthly inspections. Pharmacy management agreed that this would be required on future inspections.

We also noted only one security issue -- the door to the outpatient pharmacy vault was frequently left open during duty hours. Employees were supposed to use magnetic keycards to open the door. We discussed this issue with the Chief of Pharmacy and he acknowledged that the door was kept open because a pharmacy technician who did not have a keycard needed access to the vault in order to fill prescriptions. The Chief agreed that the technician should be issued a keycard and that staff should be required to keep the vault door shut.

Recommendation 7. To improve controls and to comply with VHA policy, the VAMC Director should ensure that (a) excess, outdated, and unused controlled substances are included in monthly inspections and (b) the outpatient pharmacy vault door is kept shut.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that by June 2000 expired drugs would be included in all

controlled substances inspections and that the VAMC had already taken action to limit access to the pharmacy vault to only those employees with magnetic keycards.

Office of Inspector General Comments. The comments and implementation plans were acceptable and we consider the issues resolved.

Medical Care Cost Fund -- Patient Means Test Forms Should Be Obtained

As part of VA Medical Care Cost Fund requirements, copayments are collected from certain veteran-patients to offset the costs of treatment provided for nonservice-connected conditions. Patients with income below certain thresholds are exempted from these copayments. Each year any patient who may be subject to copayments must provide updated income information by signing a means test income verification form. The patient's reported income is entered into a national eligibility database that is further verified with Social Security and IRS records.

During the 3-month period October 1 through December 31, 1999, the VAMC processed 72 means test cases in which the patients reported zero income. We reviewed 20 of these cases and found that for 4 cases (20.0 percent) a signed means test verification form was not in the patient's administrative file. The signed form is necessary to support the patient's reported income. If the form is not on file, the patient's identifying information could be inappropriately entered into the income verification database, which could result in unnecessary income verification match workload and/or delays in copayment collections.

According to Ambulatory Care Service management, this problem occurred because staff assigned to different tours of duty were not informing each other when patients were admitted without a current means test and key staff did not understand the importance of obtaining signed means test forms.

Recommendation 8. The VAMC Director should ensure that Ambulatory Care Service employees receive refresher training on the importance of obtaining signed means test forms.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and reported that as of April 2000 refresher training had been provided to the affected employees.

Office of Inspector General Comments. The comments and implementation actions were acceptable and we consider the issue to be resolved.

Fraud and Integrity Awareness Briefings

As part of the CAP review, Office of Investigations agents conducted four 90-minute Fraud and Integrity Awareness briefings, which included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. About 200 VAMC employees attended the briefings. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1 delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Management is required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that is not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, Division staff assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or a criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the Division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, overbilling, false claims, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, Compensation and Pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of

interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** -- Names, position titles, connection with VA, and other identifiers.
- **What** -- The specific alleged misconduct or illegal activity.
- **When** -- Dates and times the activity occurred.
- **Where** -- Where the activity occurred.
- **Documents/Witnesses** -- Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

To report suspected wrongdoing in VA programs and operations, call the OIG Hotline -- (800) 488-8244.

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the Carl T. Hayden VA Medical Center, Phoenix, Arizona

Project Number: 2000-01072-R8-0213

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
6(a) and (b)	Better use of funds through stronger collection efforts on delinquent vendor accounts receivable	$27,450	

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: April 19, 2000

From: Director, Carl T. Hayden VA Medical Center (644/00/FMS)

Subj: Draft Report, Combined Assessment Program Review, Project 2000-01072-R8-0213)

To: Assistant Inspector General for Auditing (52)

1. Attached is our response to the draft report on the Combined Assessment Program review of the Carl T. Hayden VA Medical Center here in Phoenix. We have reviewed and concur with the findings and recommendations in the April 7, 2000 report, as revised on April 13, 2000.

2. If you require any additional information or further clarification regarding the content of our response, please feel free to contact Richard Pasquale, Administrator, Financial Management Services, at (602) 222-6410.

(Original signed by Paul H. West for:)
JOHN R. FEARS

Attachments: 5

Automated VA FORM 2105

Carl T. Hayden VA Medical Center
Combined Assessment Program Review
Implementation Plan – 4/19/00

ISSUES/CORRECTIVE ACTIONS	ACTION	MONITOR	COMPLETION DATE	COMMENTS
1. Improved follow-up needed on patients with abnormal glucose test results				**Concur.**
1a. Provide refresher training on monitoring	CS Admin	Chief, QM	Jul 15, 2000	Training under the current policy will take place immediately. Training will also take place in conjunction with establishment of a new policy.
1b. Implement controls to insure compliance with testing requirements.	CS Admin	Chief, QM	Jun 15, 2000	The present Ancillary Testing Policy will be reviewed, making changes as necessary. Benchmarking efforts were initiated in conjunction with the VA Medical Center in Minneapolis, MN. Officials will work on developing monitors of compliance with policy. In addition, results of monitors will be reported to Quality Council (Inpatient Services) and Pathology & Laboratory Medicine Department (P&LMD) Staff Meeting.
2. Various Issues warranting follow-up				**Concur.**
2a. Maintain cleanliness in the patient care environment	RMS Admin.	Environmental rounds	On going	The Environmental Management Department has hired to their ceiling level and will continue to aggressively refill positions as vacancies present. Additionally, a review of EMD processes has been implemented to ensure that cleanliness standards are consistent with inspection standards. As needed resources will be funded to ensure that cleanliness standards are maintained.
2b. Find alternative storage to keep hallways clear	RMS Admin	Environmental rounds	Jul 1, 2000	During the recent renovations storage issues have been compounded. To resolve these issues excess or seldom used items have been moved to storage areas on the property. EMD staff has been informed to bring equipment storage issues to the attention of their Supervisor. The Supervisor will determine the appropriate response and resolve the issue. The Safety Office staff will also include a 'hallway' check in their regular rounds.
2c. Assess feasibility of an automatic door to improve Ambulatory Care Center accessibility	RMS Admin.	Safety Committee	Oct 1, 2000	The Asst. Administrator, Engineering will submit a local level project request to change the current ADA approved door to a different type of ADA approved door.

2d. Explore options for relocating Veteran Service Officers (VSOs) closer to patient care areas	AA/Director	Director	Completed	Earlier this month a review of current space and space potentially available within the foreseeable future was undertaken. Unfortunately, this review revealed that there is insufficient space in the area that the Service Organizations desire, the main building. The main building is the location most in demand for direct patient care and its necessary support functions. While we recognize that Service Organization activities are important to the medical center and our veteran beneficiaries, under the circumstances and at this point in time, it is difficult for medical center management to justify displacing vital functions that are already cramped for space, in favor of the non-patient care operations of the Service Organizations. A summary of this review, in the form of a memorandum signed by the Medical Center Director, will be provided to the Service Organizations at the VAVS Executive Committee meeting.
2e. Improve nursing work practices to eliminate inefficiencies	ICS Admin.	ICS Quality Management Council	Sep 1, 2000	In March, the ICS Quality Council chartered a multi-Service Line Process Improvement Team to streamline and coordinate the process across the continuum of care.
2f. Complete continued stay reviews on inpatient MH units	MH&BS Admin.	Interqual criteria	Apr 15, 2000	MH&BS coordinated the development of a Continued Stay Review Plan with the medical center's Utilization Management staff. Utilization review data will be used to coordinate care of individual patients and to optimize overall bed utilization. An outcome of the plan was the assignment of a clinical nurse specialist to perform continued stay reviews with respect to Interqual standards.
2g(1). Improve inpatients' awareness of the one physician in charge of their care.	CS Admin.	EPIC Committee	May 15, 2000	Clinical Support officials will review this concern with the Attendings, who will strive to ensure that they introduce themselves to the patients and that the patients know who is ultimately responsible for their care.
2g(2). Improve outpatient waiting times	AC Admin.	EPIC Committee	On going	Additional support staff are being hired to improve processing times at check-in and out.
2g(3). Improve employee perception that incompetence is rewarded	AA/HRMD	HR FLT	Oct 1, 2000	HRM will continue to notify employees of the Medical Center's Rewards and Recognition Program at new employee orientation, at staff meetings, via newsletters, electronic mail and other media.

2h. Improve care/documentation for patients in two focused studies (a) Only 36% of the records documented adequacy of the patient's intake (b) Only 61% of the records documented actual food intake (c) Only 53% of the records documented physician follow-up	Chair, Nutrition	Chief, QM	Jul 15, 2000	Regarding deficiencies (a) and (b) according to our Clinical Nutrition Procedure 11—Nutrition Assessment of Inpatients, the Registered Dietitian's initial assessment includes an estimation of energy/nutrition needs and assessment of adequacy of nutrient intake to meet those needs. We have requested a copy of the specific criteria used in the OIG review along with the patient list in order to specifically evaluate these finding and take corrective action. Corrective Action will include monthly focused chart audits conducted by the Chair, Clinical Nutrition to monitor adequacy of documentation. Regarding deficiency (c), as of February 2000, the NHCU Interdisciplinary Team has made changes in their care-planning format. The Registered Dietician forwards the patient's nutritional goals and interventions to the case managers for review prior to the meeting. The physician/NP, along with the other members of the Interdisciplinary team, provides any additional input/recommendations at the care planning meetings. Additionally, Clinical Nutrition has made changes in their follow-up documentation procedures. Initial nutrition assessments are formatted to clearly identify nutritional diagnosis and etiologies followed by specific goals and interventions (previously, interventions were not routinely listed separately from nutritional diagnoses and goals). At patient follow-up, the nutritional diagnoses are all reviewed and goals and interventions updated. This process assures continuity of nutrition care and that the Registered Dietitian and the physician/NP as warranted address all recommendations (interventions).
3. Inventory Levels are excessive				**Concur. Director's comment: clinical inventories were excessive largely due to increased stock levels as a Y2K precaution.**
3a. Use automated controls to reduce inventories to levels consistent with need	Chiefs, SPD, Engineering; Chairs, Prosthetics, Pharmacy	FMS Admin.	Various dates as noted in comments	SPD will continue to draw down Y2K stock of critical medical supplies, estimated completion for this is May 31, 2000. SPD will implement additional automation (autogeneration) of GIP inventory to help reduce inventory levels. Stock levels and reorder points for the top 50 (high dollar value) items will be evaluated and adjusted to ensure a maximum of no more than 30-days stock is on hand, estimated completion date for this phase is Jun 30, 2000. Ultimately, other medical supply inventory items will undergo similar evaluation/adjustment to obtain a maximum of 30-day inventory with an estimated completion date for this phase of Dec 31, 2000.

				Prosthetics to review with staff the procedures for maintaining appropriate supply levels by June 30, 2000. Inventory Worksheets provided to staff to calculate inventory level and determine re-order level to maintain a 30-day supply. Department Chair to monitor for compliance. Pharmacy to establish and place written par levels on each bar code inventory label to aid the technician in the re-order process, by June 30, 2000. This will establish actual levels as opposed to relying on the 2001. judgment of the technician. Engineering is reviewing the processes that it has in place to ensure that appropriate stock levels are maintained. Additionally, by June 30, FMS and the Engineering Department will complete a review the IFCAP/GIP process to determine if this system would be cost effective for use in Engineering at our facility.
3b. Eliminate warehouse inventories for items stocked by SPD	Chief, SPD	FMS Admin.	Dec 31, 2000	Med/Surg prime vendor contract to be awarded, followed by the phasing-out of all warehouse posted stock (Supply Fund)
4. Part-time surgeon time & attendance problematic				**Concur.**
4a. Establish controls to account for all PT surgeon work time and properly pay only for actual on-duty time	Chair, Surgery	CS Admin.	Jun 4, 2000	The Department of Surgery will review the assigned tour of duty for all part-time surgery staff and make appropriate changes so that these tours are more accurately reflective of the time spent performing physician responsibilities. The Department of Surgery, in consultation with Human Resources Management and the Payroll Section, will develop and implement an adjustable work hours schedule for part-time surgeons. This arrangement will allow for the flexibility of recording unscheduled hours for surgeons, while more accurately documenting and charging surgeons for time period in which they are not on-duty for an assigned tour. The Department of Surgery will institute a mechanism that will serve as documentation of the time and attendance of part-time surgeons. The Department of Surgery, in consultation with the Associate Chief of Staff and Administrator of Clinical Services, will assign surgeons, when appropriate, to Fee Basis arrangements wherein compensation is paid on a fee-for-service basis (target: on-going).

4b. Adjust PT surgeon appointment levels consistent with workloads	Chair, Surgery	CS Admin.	Jun 4, 2000	The Department of Surgery will provide operative and clinic workload reports for all part-time surgeons to the Associate Chief of Staff and Administrator of Clinical Services on a quarterly basis. As appropriate, appointment levels will be adjusted based on this data. There will be ongoing monitoring and adjusting as necessary.
5. Physical inventories of equipment not completed				**Concur.**
5a. Account for all items on Equipment Inventory Listings (EILs) this fiscal year	AA, A&MM	FMS Admin.	Sep 30, 2000	Physical inventory instructions will be issued with instructions for service lines to complete this work by July 15. Delinquent departments will be issued follow-up notices, signed by the Medical Center director. Tracking report will be created an implemented by July 31, 2000.
6. Delinquent efforts to collect or write-off 7. non-MCCR Accounts Receivable				**Concur.**
6a. Establish controls for pursuing delinquent receivables	Chief, Accounting	FMS Admin.	On going	Staffing has been realigned to place an additional employee in Accounting whose focus will be on keeping non-MCCR accounts receivable current.
6b. Pursue or write-off receivables identified as delinquent	Chief, Accounting	FMS Admin.	On going	The additional employee will determine if collection is possible. If not, steps will be take to write-off applicable receivables.
7. Controlled Substances issues				**Concur.**
7a. Include excess, outdated, and unused controlled substances in monthly inspections	Chair, Pharmacy	CS Admin.	June 1, 2000	Excess, outdated and unused controlled substances will be included in the monthly unannounced controlled substances inspections in the Inpatient and Outpatient pharmacies.
7b. Keep outpatient pharmacy vault door shut	Chair, Pharmacy	CS Admin.	Completed	The day gate to the Outpatient Pharmacy vault will be kept closed and access will be limited to only those employees with magnetic keycard codes.
8. Signed Means Test Forms not on file				**Concur.**
8a. Provide refresher training, emphasizing the importance of signed means test forms	AA/Amb. Care	AC Admin.	Completed and On-going	Training plan and monitors in place. All employees have received training. Future problem areas as identified by monitors will be addressed through additional training. This matter will also be a permanent agenda item for section meetings.

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