Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas

Report No. 04-00566-173

August 9, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of February 23-27, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Amarillo VA Health Care System (referred to as the System). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 325 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

This CAP review focused on 12 areas. As indicated below there were no concerns identified in five of the areas. The remaining seven areas resulted in recommendations for improvement.

The System complied with selected standards in the following areas:

- Accounts Receivable
- Controlled Substances Accountability
- Equipment Inventory Management
- Quality Management
- Environment of Care (EOC)

The following organizational strengths were identified:

- Employment of Disabled Citizens Program
- Effective Lung Cancer Initiative
- Environment of Care

To improve operations, the following recommendations were made:

- Ensure that pre-sedation assessments are implemented in the cardiology clinic; Advanced Cardiac Life Support (ACLS) certifications, annual test, and demonstrations of skills are kept up to date; and moderate sedation data is captured for quality improvement activities.
- Strengthen timekeeping controls to ensure part-time physicians meet their employment obligations.
- Ensure Automated Information Systems (AIS) users receive security awareness training, improve controls over AIS accounts of non-VA employees, and reevaluate

the Veterans Health Information Systems and Technology Architecture (VISTA) security plan.

- Enhance Medical Care Collections Fund (MCCF) collections by ensuring attending physicians document supervision of residents and improving MCCF staff's ability to identify documentation needed for billing.
- Improve documentation of contracts, request pre-award audits when required, and provide appropriate staff members with guidance concerning conflicts of interest.
- Ensure purchase cardholders consider preferred supply sources and obtain competitive price quotations when purchases exceeding $2,500 must be made on the open market.
- Reduce stock levels and maintain accurate supply inventory records.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, Dallas Regional Office of Healthcare Inspections, and Ms. Marilyn Walls, CAP Review Coordinator, Dallas Regional Office of Healthcare Inspections.

VISN 18 and System Director Comments

The VISN 18 and System Directors concurred with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendices A and B, beginning on page 14, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

(signed by Jon A. Wooditch,
Deputy Inspector General for:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Health Care System Profile

Organization. Located in Amarillo, Texas, the System provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in Lubbock, Childress, and Stratford, Texas; Clovis, New Mexico; and Liberal, Kansas. The System is part of VISN 18 and serves a veteran population of about 71,400 in a primary service area that includes 52 counties in the Texas and Oklahoma Panhandles, eastern New Mexico, and southwestern Kansas.

Programs. The System provides acute, primary, and long-term care in the areas of medicine, surgery, mental health, physical medicine care and rehabilitation, neurology, oncology, dentistry, and geriatrics. The System has 69 authorized acute hospital beds, including 14 Intensive Care Unit (ICU) beds, and 120 nursing home care unit (NHCU) beds. The System also operates an Outpatient Substance Abuse Residential Rehabilitation Treatment Program.

Affiliations. The System is affiliated with the Texas Tech University Health Sciences Center Schools of Medicine and Pharmacy. The System supports 60 medical resident positions in internal medicine, family practice, specialty care, and pharmacy. Additionally, the System has affiliations with Northeastern University School of Optometry, West Texas A&M University, and Amarillo College that provide a variety of educational opportunities in optometry, nursing, and various allied health programs.

Research. In Fiscal Year (FY) 2003, the System's research program had four projects and a budget of $87,000. Important areas of research include oncology, infectious disease, immunotherapy, and smoking cessation.

Resources. In FY 2003, medical care expenditures totaled $87.9 million. The FY 2003 medical care budget was $97.1 million. FY 2003 staffing averaged 779.2 full-time equivalent employees (FTEE), including 39.3 physician and 155.6 nursing FTEE.

Workload. In FY 2003, the System treated 28,231 unique patients. The System provided 13,691 days of care in the hospital (not including residential care) and 42,564 inpatient days of care in the NHCU. The inpatient care workload was 2,703 discharges, and the inpatient average daily census was 37.5. The NHCU average daily census was 116.6 and the outpatient workload was 200,248 visits.

Objectives and Scope of the CAP Review

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

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

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

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

Accounts Receivable	Government Purchase Card Program
Automated Information Systems Security	Management of Moderate Sedation
Contract Administration	Medical Care Collections Fund
Controlled Substances Accountability	Quality Management
Environment of Care	Supply Inventory Management
Equipment Inventory Management	Time and Attendance for Part-Time Physicians

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to all System employees and 244 responded. We also interviewed 34 patients during the review. The survey results were shared with System management.

We also presented four fraud and integrity awareness briefings for System employees. These briefings, attended by 325 employees, 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.

The review covered System operations for FY 2002, FY 2003, and FY 2004 through February 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strengths

Employment of Disabled Citizens Program. One of the System Director's priorities for workplace development is to provide meaningful work opportunities for disabled citizens of the Amarillo area. The Director spearheaded efforts with various State services in developing jobs to accommodate physically and mentally disabled citizens that capitalize on their abilities to function productively. Since 2001, the System has provided employment to over 60 people with disabilities, which equates to 9 percent of the workforce. In recognition of this effort, the System was awarded the Outstanding Employer Award by the City of Amarillo's Advisory Commission for People with Disabilities in 1997 and 2000.

Effective Lung Cancer Initiative. After identifying that lung cancer patients were presenting for treatment at late stages of the disease, the Executive Leadership Group chartered a performance improvement team. The team evaluated data and processes and made recommendations to identify patients at risk. In order to facilitate early intervention, a QM program assistant works with Radiology Service to screen patients with abnormal chest x-rays and refers them to the next appointment in the lung nodule clinic. Oncology, radiology, thoracic surgery, pulmonology, and a pulmonary function laboratory technician staff the new clinic.

The clinic meets on Monday, providing more opportunities for biopsies during the same week. The clinic scheduler makes reminder calls to all patients the Friday before their appointments to remind them of the importance of attending clinic. The QM program assistant tracks all patients during the diagnostic and treatment process, making sure no one is missed, and trends treatment data. Radiology Service has reduced the time to review abnormal x-ray results and perform biopsies, and Pathology Service has improved their reporting process and turn-around time. There are fewer missed appointments and patients are being seen at earlier stages of their disease. Because of this, more patients are surgical candidates, thus improving life expectancy.

Environment of Care. The System maintained a generally clean and safe EOC. We found no deficiencies in the areas inspected. The public restrooms were found to be clean all through the day. Managers had evacuation plans and patient representative signs posted in all clinical and non-clinical areas throughout the facility. Ninety-five percent of the employees responding to the employee satisfaction survey also stated the System is clean.

Opportunities for Improvement

Management of Moderate Sedation – Pre-Sedation Assessments Should Be Implemented in Cardiology; ACLS Certifications, Annual Written Tests, and Demonstrations of Skills Should Be Current; and Moderate Sedation Should Be Included in Quality Improvement Activities

Condition Needing Improvement. System managers needed to ensure that Veterans Health Administration (VHA) standards and System policies were being followed in all areas where moderate sedation is given. The System needed to ensure that the cardiology clinic completes pre-sedation assessments, that providers have current ACLS certifications, and that annual tests and demonstrations of skills are completed. The System did not capture moderate sedation procedures performed in the ICU. The System should also ensure that moderate sedation is included in QM reviews.

To evaluate the management of moderate sedation, we reviewed policies and procedures, a judgment sample of 12 patients' medical records, and 6 providers' credentialing and training files. We also interviewed key employees, inspected treatment areas, and reviewed the quality improvement processes related to moderate sedation.

Pre-Sedation Assessments. System policy requires that patients receive a pre-sedation American Society of Anesthesiologists (ASA) classification before receiving moderate sedation. The ASA classification is a ranking of the patient's physical status and corresponding risk of sedation that determines whether an anesthesia consult is recommended. We reviewed two medical records in the cardiology clinic and found no ASA classification documentation.

Credentialing and Training. System policy requires ACLS certification, demonstrations of skills, and annual written tests. We reviewed the credentialing and training files of six providers, including two physicians and four Registered Nurses (RN). We found two providers with expired ACLS certifications (one contract physician and one RN). We found one of four RNs had not completed a required test. For the three RNs who completed the test, there was no evidence it had been done annually. We also found that, until 2 weeks prior to our CAP review, the demonstrations of skills for four RNs had not been completed for the previous 2 years.

Performance Monitoring. The Joint Commission on Accreditation of Healthcare Organizations requires adverse event monitoring for moderate sedation. We found no evidence of QM activities to monitor the performance of moderate sedation. QM employees stated they did not monitor moderate sedation because there had been no adverse events. However, data was not captured in all areas where moderate sedation was performed.

Recommended Improvement Action(s) 1. We recommended that the VISN Director and the System Director ensure that: (a) cardiology clinic patients receive ASA classifications prior to moderate sedation; (b) System policy concerning ACLS certification, annual written tests, and demonstrations of skills is followed; and (c) all moderate sedation data, including ICU and cardiology procedures, is captured in performance improvement monitoring.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Time and Attendance for Part-Time Physicians – Timekeeping Controls Needed To Be Strengthened

Condition Needing Improvement. The System needed to strengthen timekeeping controls to provide reasonable assurance that part-time physicians were meeting their employment obligations.

Changes to Non-Core Hours. Part-time physicians' work hours include core hours that the employees must work and non-core hours that are adjustable. Except for medical emergencies, VHA policy requires that employee requests to modify non-core hours be made in advance by the employee, approved in writing by the employee's supervisor, and communicated to the timekeeper as soon as possible.

To verify that part-time physicians were performing VA work during scheduled hours, we attempted to locate 10 of the System's 12 part-time physicians during their scheduled work hours. At the time of our observation, six were scheduled for core hours and four were scheduled for non-core hours. Two of the part-time physicians scheduled for non-core hours were not performing VA work, were not on approved leave, and had not requested modifications of their scheduled tours of duty in advance. This occurred because staff misunderstood criteria and did not realize that modifications to non-core hours must be requested in advance.

Time and Attendance Records. VA policy states that part-time physicians will record their hours of duty and leave each week on a subsidiary time sheet (VA Form 4-5631a, *Subsidiary Time and Attendance Report for Part-Time Physicians*) and sign it. The part-time physicians' supervisors must approve the subsidiary time sheets. We examined the subsidiary time sheets for six part-time physicians for the most recent pay period prior to the date of our review. For five of the six part-time physicians, the Medical Service timekeeper or alternate timekeeper, not the physicians, had completed the subsidiary time sheets, part-time physicians had not signed the time sheets, and supervisors had not approved them.

Timekeeper Desk Audits. VA policy requires semiannual desk audits of each timekeeper. System policy directs Human Resources Management Service (HRMS) staff to perform the semiannual desk audits of part-time physicians' timekeepers and to document the results using a prescribed checklist, which includes a step to determine whether the part-time physicians appropriately completed the subsidiary time sheets. We requested reports of the desk audits completed in 2003 for five timekeepers responsible for part-time physicians' timekeeping. Only one desk audit had been completed and documented with the prescribed checklist for each timekeeper. HRMS staff had not completed the required second desk audits of three of the five timekeepers and had not documented two other desk audits using the prescribed checklist. If HRMS staff had completed the required desk audits and used the prescribed checklist, they might have determined that part-time physicians were not preparing their own subsidiary time sheets.

Recommended Improvement Action(s) 2. We recommended the VISN Director ensure that the System Director requires that: (a) part-time physicians obtain their supervisors' approval in writing prior to changing their non-core work hours and communicate the changes to the timekeepers as soon as possible, (b) subsidiary time sheets be completed and signed by part-time physicians and approved by the part-time physicians' supervisors, and (c) semiannual desk audits be performed and appropriately documented for all timekeepers.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Automated Information Systems Security – Controls over Training, Non-VA Employee Accounts, and Security Planning Needed Improvement

Condition Needing Improvement. The System needed to ensure that AIS users receive security awareness training, improve controls over AIS accounts of non-VA employees, and reevaluate the VISTA security plan.

Computer Security Awareness Training. VHA policy states that any individuals given access to Federal AIS must receive a security awareness briefing as part of their orientation training and must receive annual refresher training. We identified 43 System employees with Local Area Network access who did not receive AIS security awareness training during FY 2003. In addition, we could not determine whether non-VA employee AIS users received the required security awareness training because the System did not track security awareness training for non-employees.

Control of Non-VA Employee VISTA Accounts. VHA policy states that AIS user access and privileges must be reviewed at least every 90 days to ensure appropriate levels of

access and continued need. Also, VHA policy requires System personnel to disable AIS accounts that have been inactive for 90 days.

We identified 16 non-VA employee VISTA accounts that had not been accessed in more than 90 days and had not been disabled. These accounts had not been accessed for periods ranging from 146 to 1,119 days.

System personnel were not able to list non-VA employee AIS users. Although there is no specific requirement to differentiate employees from non-VA employees in user profiles, doing so would facilitate review of the appropriateness of access levels and the continued need for access.

VISTA Security Plan. VHA policy requires each facility to develop and implement "station-specific information security policy and procedures." However, several characteristics of the VISTA security plan indicated the plan was a duplicate of a sample security plan and was not station-specific.

- The pages of the plan were numbered 123 through 165.
- The table of contents referred to pages 91-94, which were not included in the plan.
- The plan cited "Any Veterans Affairs Health Care System" in 29 places where the facility name should have been inserted.
- The plan referred to a May 2003 review of the facility by the Government Accountability Office (GAO). When we asked for a copy of the report, we were told that there was no such GAO review.

System personnel needed to revise the VISTA security plan to ensure the plan reflects the System's specific circumstances and requirements.

Recommended Improvement Action(s) 3. We recommended the VISN Director ensure that the System Director takes action to: (a) ensure all AIS users, including non-VA employees, receive security awareness briefings during orientation training and receive annual refresher training; (b) disable AIS accounts that are inactive more than 90 days; (c) indicate in VISTA user profiles whether the users are employees, contractor personnel, volunteers, or affiliated educational institution personnel; and (d) revise the VISTA security plan to ensure it reflects the System's specific circumstances and requirements.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Medical Care Collections Fund – Collections Could Be Enhanced by Documenting Resident Supervision and Providing Training Concerning Identification of Documentation Needed for Billings

Condition Needing Improvement. System managers could enhance MCCF collections by ensuring that attending physicians adequately document supervision of residents and improving MCCF staff's ability to identify documentation supporting billings to insurance carriers.

Resident Supervision Not Documented. System managers needed to ensure that attending physicians documented their supervision of residents in veterans' medical records. VA policy requires that insurance carriers be billed for care provided by residents and that resident care be properly supervised by attending physicians. The *Reasons Not Billable Report* for the 3-month period ending November 30, 2003, showed that MCCF staff canceled 373 potential billings totaling $66,838 using reason codes indicating the patients' medical records contained no documentation or insufficient documentation for billing or that care was provided by non-billable resident providers. We analyzed a judgment sample of 30 of the 373 potential billings totaling $22,005 and found that 18 potential billings totaling $15,800 could not be billed because the patients' medical records did not contain documentation of the attending physicians' supervision of residents.

Prior to our review, System managers recognized the need to improve documentation of resident supervision and initiated corrective action. In September 2003, the Chief, Health Information Management began monitoring documentation of resident supervision. On January 16, 2004, the Acting Chief of Staff issued a memorandum providing specific documentation requirements. The Acting Chief of Staff also conducted training on this issue on January 30, 2004.

Potential Billings Overlooked. Six of the 30 potential billings in our sample were not submitted to insurance carriers because MCCF staff mistakenly thought they did not have sufficient documentation for billing. This occurred because MCCF staff did not review the patients' hardcopy medical records or overlooked pertinent documentation in the patients' electronic medical records. As a result of our review, the MCCF Coordinator referred five of these records to MCCF staff for issuance of billings totaling $3,017. MCCF staff did not issue the other potential billing of $849 because the health insurance carrier's 90-day deadline for billings had expired before our review.

Recommended Improvement Action(s) 4. We recommended the VISN Director ensure that the System Director requires that: (a) the Chief, Health Information Management continue monitoring the documentation of resident supervision and provide attending physicians with training concerning documentation requirements and (b) the MCCF staff receive refresher training concerning identification of documentation needed

for billing insurance carriers and closely monitor the *Reasons Not Billable Report* for missed billing opportunities.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Contract Administration – Contracts Should Be Properly Documented, Pre-Award Audits Should Be Requested When Required, and Supervisors Should Receive Guidance Concerning Conflicts of Interest

Condition Needing Improvement. System managers needed to ensure that contracts were properly documented, pre-award audits were requested when required, and appropriate staff members received guidance concerning conflicts of interest.

Contract Documentation. To evaluate System contracting activities, we reviewed documentation for 15 contracts with an estimated combined value of $3.8 million. Of the 15 contracts, 9 were noncompetitive acquisitions and 6 were competitive. We identified the following deficiencies in the contract files:

- The Federal Acquisition Regulation (FAR) requires contracting officers to prepare price negotiation memoranda (PNM) providing the names of persons involved in the contract negotiations, explanations of differences between the contractors' and VA's positions, documentation of fair and reasonable pricing, and other pertinent information. Two of the nine contract files for noncompetitive acquisitions did not contain PNMs, and the PNM in the file for another noncompetitive acquisition did not include all of the required information.
- The FAR permits noncompetitive contracts only if the need for noncompetitive acquisitions is justified in writing. The contract files for six of the nine noncompetitive contracts reviewed did not include justifications for noncompetitive acquisition.
- Modifications to three noncompetitive contracts had not been signed by the contractors.

Pre-Award Audits. VHA policy requires pre-award audits of all noncompetitive contracts with estimated values of $500,000 or more. One of the nine noncompetitive contracts reviewed had an estimated value of $540,000, but System contracting officials did not request a pre-award audit.

Guidance Concerning Conflicts of Interest. VHA policy requires that each Chief of Staff and physician supervisor or manager receive a copy of VHA Handbook 1660.3, *Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services and Health Care Sharing*, and acknowledge its receipt in writing. HRMS staff had determined that

77 System employees should receive a copy of the handbook. However, at the time of our review, only 23 employees had received their copies and acknowledged receipt in writing.

Recommended Improvement Action(s) 5. We recommended the VISN Director ensure that the System Director requires that: (a) adequate documentation be maintained in contract files, including PNMs containing all required information, written justifications for noncompetitive acquisitions, and signed contract modifications; (b) pre-award audits be done for all noncompetitive contracts with estimated values of $500,000 or more; and (c) all appropriate personnel receive VHA Handbook 1660.3 and acknowledge receipt in writing.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Government Purchase Card Program – Cardholders Needed to Consider Preferred Supply Sources and Obtain Competitive Price Quotations When Making Open Market Purchases

Condition Needing Improvement. Cardholders needed to consider the use of preferred supply sources and seek competition for open market purchases exceeding $2,500. During the 7-month period ending November 30, 2003, cardholders completed 8,124 transactions totaling $4.3 million.

The FAR directs purchase cardholders to promote competition to the maximum extent possible for transactions exceeding $2,500 by soliciting quotations from at least three sources when supply needs cannot be met from preferred sources such as national VA contracts, blanket purchase agreements, and Federal Supply Schedule contracts.

We reviewed a judgment sample of 13 purchase card transactions exceeding $2,500 that occurred during the 7-month period ending November 30, 2003. Cardholders made five purchases totaling $30,048 without using preferred sources and without seeking competition. These included three purchases of prosthetics items and two purchases of landscaping services.

Cardholders did not consider preferred supply sources for the three purchases of prosthetics items, and lower prices might have been available. For example, a cardholder purchased knee replacement components from a national supplier at a cost of $7,866. Similar items were available at prices ranging from $6,470 to $6,706 from a different vendor on a national contract awarded by the VA National Acquisition Center. To ensure VA gets the most advantageous prices, purchase cardholders should use preferred sources whenever feasible and solicit quotations from at least three sources when they must make open market purchases.

Recommended Improvement Action(s) 6. We recommended the VISN Director ensure that the System Director requires purchase cardholders to consider preferred supply sources and solicit at least three quotations when purchases exceeding $2,500 must be made on the open market.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Supply Inventory Management – Stock Levels Should Be Reduced and Inventory Records Should Be Accurate

Condition Needing Improvement. The System needed to reduce stock levels and maintain accurate inventory records. VHA policy establishes a 30-day supply goal and requires medical facilities to use the automated Generic Inventory Package (GIP) to manage inventories. Managers should use GIP to establish stock levels, analyze receipts and distributions, and determine order quantities.

At the time of our review, GIP showed the System inventory included 1,294 line items valued at $362,212. To assess stock levels, we analyzed GIP data for all line items. In addition, we inventoried quantities on hand and reviewed usage rates for a judgment sample of 25 line items to assess the appropriateness of the normal stock levels established by inventory managers[1] and the accuracy of inventory records. The 25 line items in our sample had a combined value of $21,526.

Excess Stock. GIP data indicated that the System had stock in excess of a 30-day supply for 1,179 of the 1,294 (91 percent) line items in the inventory. Our analysis of normal stock levels established for the 25 line items in our judgment sample showed that the normal stock levels for 14 line items inappropriately exceeded a 30-day supply. The normal stock levels for these items ranged from 31 to 240 days. Reducing stock levels would reduce holding costs and make more funds available for other uses.

Inaccurate Inventory Records. The quantities recorded in GIP were inaccurate for 5 of the 25 line items reviewed, with 3 overages valued at $277 and 2 shortages valued at $344. Inaccurate inventory records hinder efforts to maintain appropriate stock levels and efficiently use limited funds.

Recommended Improvement Action(s) 7. We recommended the VISN Director ensure that the System Director requires inventory managers to: (a) reduce stock levels to more closely adhere to the 30-day supply goal, (b) correct the specific deficiencies we identified in inventory records, and (c) emphasize the importance of maintaining accurate inventory records.

[1] The normal stock level represents the largest amount of an item to be maintained in the inventory.

The VISN and System Directors concurred with the findings and recommendations and submitted plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Appendix A

VISN 18 Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 16, 2004

From: Network Director, VISN 18 (10N18)

Subject: **Amarillo VA Health Care System, Amarillo, Texas**

To: Assistant Inspector General for Health Care Inspections
Peggy Seleski, Director, Management Review Service (10B5)

I concur with the attached facility response on the recommendations for improvement contained in the draft Combined Assessment Program review at the Amarillo VA Health Care System. We are concurring with all of the recommendations contained in the draft report. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A. McKlem

Attachment

Appendix B

Amarillo VA Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2004

From: Director, Amarillo, VA Health Care System

Subject: **Amarillo VA Health Care System, Amarillo, Texas**

To: Network Director, VISN 18 (10N18)

Attached is the Director's response on the recommendations for improvement contained in the draft Combined Assessment Program review at the Amarillo VA Health Care System. If you have any questions or concerns, please contact Linda Hill, Executive Assistant to the Director, at 806-354-7801.

WALLACE M. HOPKINS, FACHE

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommend that the VISN Director and the System Director ensure that: (a) cardiology clinic patients receive ASA classifications prior to moderate sedation; (b) System policy concerning ACLS certification, annual written tests, and demonstrations of skills is followed; and (c) all moderate sedation data, including ICU and cardiology procedures, is captured in performance improvement monitoring.

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

(a) CAP recommendation to utilize the Pre-Procedure IV Sedation form to document pre-procedure assessment for patients who are to undergo transesophogeal echocardiograms (TEE) was discussed at the March Special Care Committee meeting and approved for use. This is the only cardiac procedure that is done here under moderate sedation.

Completion Date: Process implemented June 21, 2004, and will be ongoing

(b) ACLS certification, annual written tests, and demonstration of skills for competency verification for all staff conducting moderate sedation are outlined in Medical Center Memorandum 112-06. Tracking of compliance for all staff providing moderate sedation will be the responsibility of the Administrative Officer of Surgery and Medicine for physicians and the appropriate Nurse Managers that supervise RNs assisting with moderate sedation.

Completion Date: Process implemented April 1, 2004, and will be ongoing

(c) Performance Improvement will continue to monitor pre-procedural assessment of moderate sedation. Compliance will be reported through Special Care Committee and reviewed by the Executive Committee of the Medical Staff on a quarterly basis.

Completion Date: July 1, 2004, and implementation will be ongoing

Recommended Improvement Action(s) 2. We recommend the VISN Director ensure that the System Director requires that: (a) part-time physicians obtain their supervisors' approval in writing prior to changing their non-core work hours and communicate the changes to the timekeepers as soon as possible, (b) subsidiary time sheets be completed and signed by part-time physicians and approved by the part-time physicians' supervisors, and (c) semiannual desk audits be performed and appropriately documented for all timekeepers.

Concur **Target Completion Date:** July 11, 2004

(a) Medical Service, in conjunction with Human Resources and Payroll, is diligently pursuing any available means for all part-time physicians to obtain approval in writing prior to changing non-core work hours. This is problematic at times due to the nature of some specialties and the demands on their schedule that create unavoidable fluctuations. At the same time, it is imperative that the facility retains the very scarce and absolutely vital services of these physician specialists.

Completion Date: July 1, 2004

(b) Subsidiary time sheets are being completed and signed by part-time physicians and signed by the physicians' supervisors. The timekeeper assists the part-time physicians with the process for completion of these time sheets.

Completion Date: July 11, 2004

(c) All desk audits and training for timekeepers are current. A system is in place by Human Resource Management that will ensure that future audits and timekeeper time are completed in a timely manner.

Completion Date: June 25, 2004

Recommended Improvement Action(s) 3. We recommend the VISN Director ensure that the System Director takes action to: (a) ensure all AIS users, including non-VA employees, receive security awareness briefings during orientation training and receive annual refresher training; (b) disable AIS accounts that are inactive more than 90 days; (c) indicate in VISTA user profiles whether the users are employees, contractor personnel, volunteers, or affiliated educational institution personnel; and (d) revise the VISTA security plan to ensure it reflects the System's specific circumstances and requirements.

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

(a) AIS users, including non-VA employees, currently receive security awareness briefings during orientation training by the ISO and receive web-based security awareness refresher training annually thereafter. However, a tracking system will be put in place by the ISO to ensure 100% compliance with this requirement.

Target Completion Date: July 30, 2004

(**b)** Amarillo has a nationally mandated policy in place to automatically disable AIS accounts that are inactive more than 90 days. The ISO has drafted Medical Center Memorandum 007-06 that requires all network and VISTA accounts that have been inactive for 30 days be reviewed by the associated service ADPAC. The ADPAC must then send a report back to IRM within 3 working days and indicate if an account should be deactivated and why. This Medical Center Memorandum 007-06 has been drafted and is in the final review process. The monitoring process is in place on a trial basis. This monitoring process shall become permanent after Medical Center Memorandum 007-06 is signed.

Target Completion Date: Estimated formal approval of Medical Center Memorandum 007-06-2004 is expected to occur by July 19, 2004

(c) The ISO and Chief of IRM service have delegated this responsibility to the network and VISTA system managers. Each network and VISTA account will be flagged to indicate if the users are VA employees, contractors, volunteers, or affiliated educational institution personnel.

Target Completion Date: Due to the large number of accounts, the estimated completion date is Sept. 30, 2004

(d) The VISTA security plan is undergoing annual review as part of the FISMA survey process.

Target Completion Date: July 19, 2004

Recommended Improvement Action(s) 4. We recommend the VISN Director ensure that the System Director requires that: (a) the Chief, Health Information Management continue monitoring the documentation of resident supervision and provide attending physicians with training concerning documentation requirements and (b) the MCCF staff receive refresher training concerning identification of documentation needed for billing insurance carriers and closely monitor the *Reasons Not Billable Report* for missed billing opportunities.

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

(a) Prior to the OIG visit, MCCF had identified Resident billing as a potential billing problem. As stated, the Acting Chief of Staff issued a memorandum providing specific documentation requirements for Residents and Attending physicians and also conducted training on this issue on January 30, 2004. Coding & MCCF monitored Resident documentation and Attending Physician co-signatures on a monthly basis for 3 months and reported the results through the Data Validation Committee. All the data reviewed by the OIG was dated prior to January 30, 2004, and did not reflect changes initiated by Acting Chief of Staff.

Completion Date: Training completed January 30, 2004, and monitoring is on-going

(b) As a result of the audit, 6 of the 30 potential billings in the OIG sample were identified as not submitted to insurance carriers because MCCF staff mistakenly thought they did not have sufficient documentation requirements. Upon further review of the six hard copy patient records, the progress notes were found, and billing was completed. The coding group falls under Health Information Management Section (HIMS) at the Amarillo VA Health Care System, and the coders work closely with MCCF on billing problems. In the future, when a patient visit shows non-billable during coding due to lack of documentation, the coder will request the hard copy patient record. If there is no note in the system or hard copy record, the coder will contact the physician to see where the progress note is. MCCF will continue to review the Reasons Not Billable Report on a monthly basis for missed billing opportunities.

Completion Date: June 1, 2004, and ongoing

Recommended Improvement Action(s) 5. We recommend the VISN Director ensure that the System Director requires that: (a) adequate documentation be maintained in contract files, including PNMs containing all required information, written justifications for noncompetitive acquisitions, and signed contract modifications; (b) pre-award audits be done for all noncompetitive contracts with estimated values of $500,000 or more; and (c) all appropriate personnel receive VHA Handbook 1660.3 and acknowledge receipt in writing.

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

(a) Refresher training for all contracting personnel will be provided within the next 90 days to cover required contract documentation. As a result of that training, we will develop a checklist to be inserted into each contract folder which identifies the required documentation. An annual review of each contract file will be conducted to ensure that proper documentation is present.

Target Completion Date: September 30, 2004

(b) All noncompetitive contracts will be reviewed by the Chief, A&MM Service prior to solicitation to determine the total estimated value of the contract and whether any pre-award audits are required. A written statement of review and determination will be forwarded by the Chief, A&MM Service to the appropriate Contracting Officer.

Completion Date: July 1, 2004

(c) Human Resource Management Service is distributing the VHA Handbook 1660.3 to all appropriate staff and filing an acknowledgement of receipt in the employee's OPF.

Target Completion Date: July 19, 2004

Recommended Improvement Action(s) 6. We recommend the VISN Director ensure that the System Director requires purchase cardholders to consider preferred supply sources and solicit at least three quotations when purchases exceeding $2,500 must be made on the open market.

Concur **Target Completion Date:** June 2005

All purchasing personnel (including all purchase cardholders) were provided with contracting hierarchy training in March and April 2004. Each individual was required to certify receipt of this training. Cardholders with authority to make purchases exceeding $2,500 were provided with refresher training in June of 2003, and this will be repeated every 2 years. The content of this training includes the need to solicit competition for these types of purchases.

Target Completion Date: Recurrent training is due in June 2005

Recommended Improvement Action(s) 7. We recommend the VISN Director ensure that the System Director requires inventory managers to: (a) reduce stock levels to more closely adhere to the 30-day supply goal, (b) correct the specific deficiencies we identified in inventory records, and (c) emphasize the importance of maintaining accurate inventory records.

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

(a) We continue to fully implement the Generic Inventory Package (GIP) to fully automate the inventory process. As we accomplish this implementation, we are striving to reduce inventory levels as appropriate. Once we have achieved full implementation of the automation process, we should easily be able to identify all items that should have reduced inventory levels.

Target Completion Date: September 30, 2004

(b) The specific deficiencies identified during the OIG CAP review were corrected. Adjustment vouchers are on file to document these corrections.

Completion Date: April 1, 2004

(c) All inventory management personnel will be routinely reminded of the importance of maintaining accurate inventory records. Spot checks will be conducted to ascertain the level of compliance.

Implementation Date: April 1, 2004, and ongoing

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Appendix D

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