Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Central California Healthcare System Fresno, California

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VA Office of Inspector General
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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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Introduction

During the week of June 21-25, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Central California Healthcare System (the healthcare system), which is part of Veterans Integrated Service Network (VISN) 21. 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 149 employees.

Results of Review

This CAP review focused on 17 areas. There were no concerns identified in the following nine areas:

- Accounts Receivable
- Acute Medical Units
- Contract Nursing Home Care
- Environment of Care
- Moderate Sedation
- Nursing Home Care Unit
- Primary Care Clinics
- Quality Management Program
- Service Contracts

During the CAP review, the following reported accomplishments were identified:

- An annual healthcare system-sponsored food drive benefits the community and improves VA morale.
- The healthcare system received an Excellence in Business award presented by a local community group.

We identified four areas that needed additional management attention. To improve operations, the following recommendations were made:

- Improve Medical Care Collections Fund (MCCF) procedures by verifying insurance information, reducing unbilled claims, and improving clinical documentation.
- Strengthen supply inventory controls by correcting unit-of-issue conversions, recording inventory transactions, and monitoring and maintaining proper inventory levels.
- Improve monitoring, delivery, and refill procedures for the bulk oxygen utility system.
- Strengthen Equipment Inventory Listing (EIL) controls to ensure EILs are up-to-date, accurate, and complete.

Suggestions for improvement were made in the following areas:

- Strengthen Government Purchase Card Program internal controls by ensuring monthly audits are performed, transactions are promptly certified, and documentation is maintained when purchase cards are deactivated.
- Terminate system access privileges for separated employees, and establish procedures to ensure the monitoring of Internet usage.
- Strengthen controlled substances accountability policies and procedures.
- Conduct unannounced audits of the Agent Cashier at least every 90 days on a random schedule, and ensure that the Agent Cashier turnover rate is calculated correctly.

This report was prepared under the direction of Ms. Janet C. Mah, Director, and Mr. Jeffrey West, CAP Review Coordinator, Los Angeles Audit Operations Division.

VISN and Healthcare System Director Comments

The VISN 21 Director and the Healthcare System Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendixes A and B, pages 16-29 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Healthcare System Profile

Organization. The healthcare system provides inpatient and outpatient health care services in Fresno, California, and provides outpatient care at community-based outpatient clinics located in Atwater and Tulare, California. The healthcare system is part of the VA Sierra Pacific Network (VISN 21) and serves a veteran population of about 113,660 in a primary service area that includes six counties in California.

Programs. The healthcare system provides medical, surgical, and mental health care services. The healthcare system has 157 hospital beds.

Affiliations and Research. The healthcare system is affiliated with the University of California, San Francisco and supports 42 medical resident positions. The healthcare system is also affiliated with several colleges to provide clinical training opportunities for nursing, optometry, and allied health students. In Fiscal Year (FY) 2003, the healthcare system's research program had 28 projects and a budget of about $259,000. Areas of research include prevention and treatment of atherosclerosis, home telemedicine, Alzheimer's disease, diabetes, and Post-Traumatic Stress Disorder.

Resources. In FY 2003, the healthcare system's medical care expenditures totaled $97.6 million. The FY 2004 medical care budget was $101.9 million, a 4.4 percent increase over FY 2003 expenditures. FY 2003 staffing was 772.5 full-time equivalent employees (FTE), including 47.6 physician and 239.1 nursing FTE.

Workload. In FY 2003, the healthcare system treated 22,610 unique patients, a 3.3 percent increase over FY 2002. Healthcare system officials attributed the increase to the positive image of the healthcare system within the community and the Fresno area's increased retiree population. The FY 2003 inpatient care workload totaled 2,665 discharges, and the average daily census was 88. The outpatient workload was 233,427 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 services. The objectives of the CAP review are to:

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of 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. The review covered healthcare system operations for FYs 2002, 2003, and 2004 through June 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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
- Acute Medical Units
- Agent Cashier
- Bulk Oxygen Utility System
- Contract Nursing Home Care
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Medical Care Collections Fund
- Moderate Sedation
- Nursing Home Care Unit
- Primary Care Clinics
- Quality Management Program
- Service Contracts
- Supply Inventory Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Reported Accomplishments section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-15). For these activities, we made recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and healthcare system managers until corrective actions are completed. For the activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees and 146 responded. We also interviewed 30 patients during the review. We discussed the interview and survey results with healthcare system managers.

During the review, we also presented four fraud and integrity awareness briefings to 149 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Reported Accomplishments

Annual Food Drive Benefits Community and Improves VA Morale. In 1999, the healthcare system started the Honcho Exchange Labor Program to respond to a severe food shortage in the community. To encourage food donations and foster the morale of healthcare system employees, the Healthcare System Director agreed to work an hour in any area of the healthcare system where the employees donated at least 100 cans of food. During the first month of the program, employees responded by donating 4 tons of food that was transferred to local food banks and food relief agencies. Since the program's inception, the Healthcare System Director has worked in several positions, including housekeeper, nursing assistant, groundskeeper, pharmacy aide, file clerk, and food tray line assistant, and the facility has donated an average of 3 to 5 tons of food to the community each year.

Healthcare System Honored by the Community. The healthcare system received a 2003 Excellence in Business Award for providing cutting-edge health care to 22,000 veterans in the Central Valley and for its leadership in research, teaching, and community service. The award, presented by a local Fresno newspaper, the Fresno Economic Development Council, and the Fresno Chamber of Commerce, honored businesses in Central California for their quality products and services, commitment to customers and employees, and support of economic growth and the local community.

Opportunities for Improvement

Medical Care Collections Fund – Insurance Verification, Unbilled Claims Reduction, and Clinical Documentation Needed Improvement

Conditions Needing Improvement. Under the MCCF program, VA is authorized to recover the cost of treating insured veterans from health insurance companies. During FY 2003, the healthcare system achieved over 100 percent of its MCCF collection goal, with $3,771,589, or 81 percent of the goal attained through collections from first and third party insurers for outpatient services provided. However, MCCF managers could further improve MCCF program results by verifying insurance information, reducing unbilled claims, ensuring clinical documentation is complete and timely, and having clinicians respond to MCCF staff requests for additional information to support billings.

Verification of Insurance Information. During March 2004, the healthcare system's Veterans Health Information Systems and Technology Architecture (VistA) system did not have insurance information recorded for 65 veterans. We reviewed a judgment sample of 10 of the 65 veterans. Insurance information for 4 of the 10 veterans had not been verified and updated because the veterans did not have appointments. Of the remaining six veterans, pre-registration clerks had not properly annotated four records to show the veterans did not have insurance, and had not verified two veterans insurance information.

The MCCF Coordinator stated the clerks had been trained to verify and update patient insurance information as part of their training on the patient registration process. However, prior to the CAP review, the MCCF Coordinator realized that the clerks were not always properly verifying and updating the veterans' insurance information. As a result, the MCCF Coordinator required the clerks to attend refresher patient registration training on June 9 and 17, 2004, that emphasized the proper procedures for verifying and updating insurance information.

Unbilled Claims. The March 31, 2004, *Unbilled Amounts* report showed the healthcare system had 15,121 encounters totaling $3,393,242 that had not been processed for billing. We reviewed a judgment sample of nine unbilled outpatient encounters valued at $65,449 with service dates more than 6 months old. Of the nine unbilled outpatient encounters, six valued at $43,539 were not billable. The remaining three unbilled outpatient encounters were billable, and MCCF staff created bills totaling $19,056 for these encounters during our review. For 1 of the 3 unbilled encounters, the healthcare system only billed for $437 of the total care provided because $4,359 in expenses were no longer billable based on the insurer's billing policy. Based on the healthcare system's FY 2004 third-party insurer collection rate of 24 percent, MCCF staff could have potentially collected about $5,620 [($19,056 + $4,359) x 24 percent] if the three encounters had been billed more timely.

The MCCF Coordinator stated that the delays in billing occurred due to personnel shortages in the MCCF section. To address the delays, the MCCF Coordinator initiated a project on June 8, 2004, 2 weeks prior to the start of the CAP review, to review the healthcare system's unbilled claims and create bills when appropriate.

Clinical Documentation. Before MCCF staff can bill insurers for care provided to veterans, clinicians must prepare timely and complete documentation of the care provided during outpatient encounters. Consequently, Veterans Health Administration (VHA) policy requires clinicians to enter documentation into the medical record at the time of each outpatient encounter. For the 6-month period, October 2003 through March 2004, we reviewed a judgment sample of 43 encounters with pending billings from the healthcare system's May 12, 2004, *Reasons Not Billable* report and examined the corresponding progress notes in the medical records. Of the 43 encounters, 8 were not billable under the terms of the veterans' insurance plans, and 5 had already been billed. The remaining 30 encounters, valued at $13,337, had not been billed because of insufficient or missing clinical documentation.

- Twenty-five pending bills valued at $12,289 for care provided between October 6, 2003, and March 16, 2004, had not been issued due to insufficient clinical documentation. At the time of the CAP review, Medical Records staff had requested that the 25 clinicians who provided the care supply additional clinical documentation (i.e., patient diagnosis) required for these bills. However, only three clinicians responded to the request before the start of the CAP review. After we identified these 25 cases, the Coding Compliance Coordinator contacted the remaining 22 clinicians and obtained the needed information to issue the bills. Based on the healthcare system's third-party insurer collection rate of 24 percent, the healthcare system could potentially collect about $2,949 ($12,289 x 24 percent) for these 25 encounters. The Coding Compliance Coordinator stated that the clinicians may not have been timely in responding to the requests due to the high volume of daily electronic reminders they receive. The Associate Healthcare System Director and the Healthcare System Compliance Officer agreed to develop and implement policies and procedures for clinical documentation to support billings.
- Five pending bills valued at $1,048 had to be canceled because clinicians had not documented the encounters in the medical records at the time of the visits. The five outpatient encounters had occurred more than 6 months before our CAP review. The MCCF and Coding Compliance Coordinators stated that it would be inappropriate, after extended delays, for the clinicians to record the encounters in the medical records and that these pending bills should be canceled. Based on the healthcare system's FY 2004 third-party collection rate of 24 percent, MCCF staff could have potentially collected about $252 ($1,048 x 24 percent) for these five bills if the clinical documentation had been timely completed.

Better clinical documentation and improved billing procedures would have resulted in increased reimbursements. In total, MCCF staff could have increased collections by $8,821 based on our review. The Associate Healthcare System Director, the Healthcare System Compliance Officer, and the MCCF Coordinator agreed and provided us with acceptable plans to address the documentation and billing issues.

Recommended Improvement Action 1. We recommended that the VISN Director ensures that the Healthcare System Director requires: (a) MCCF staff verify insurance information for all veterans with unidentified insurance, (b) the MCCF Coordinator develops and implements monitoring procedures to ensure that bills are issued promptly, and (c) clinicians record complete and timely documentation in the medical records.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported several improvements in the MCCF program. Training has been provided to patient registration staff and quarterly training events will be held on insurance verification. Program controls have been established to ensure the immediate verification of late insurance information provided by inpatients, to monitor adherence to insurance verification procedures, and to identify all unbilled events. In addition, the MCCF Coordinator has begun reviewing MCCF billing productivity and bi-weekly monitoring data related to provider documentation; new MCCF billing staff have been hired; and MCCF staff have begun reviewing all encounters rejected because of missing medical documentation. Finally, provider-specific clinical documentation training is being provided, and bi-weekly and quarterly audits have been implemented to identify deficiencies and monitor clinical documentation performance improvement. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. VHA policy established a 30-day supply goal and requires that medical facilities use VA's automated Generic Inventory Package (GIP) to manage medical supply inventory. Inventory managers can use GIP and the Prosthetics Inventory Package (PIP) to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and conduct physical inventories.

To determine the accuracy of reported supply inventory levels, we selected a judgment sample of 20 medical supply line items and 10 prosthetics supply line items and compared actual quantities on hand to quantities reported in the inventory systems. Our review found two areas where Facility Management Service (FMS) and Support Services managers could strengthen medical and prosthetics supply inventory controls.

Reported Stock Quantities and Value. Prosthetics inventory supply information in PIP accurately reflected supply levels on hand. However, information in GIP did not accurately reflect medical supply stock levels and values. Unit-of-issue conversions were

not correct in GIP for 3 of the 20 medical supply items reviewed. For example, GIP showed that there was 1 unit of a medical supply item in stock, even though GIP should have shown there were 500 units in a box available for issuance. In addition, for 16 of the 20 medical supply line items reviewed, Support Services staff had not properly updated GIP as supplies were issued from inventory.

As a result, our physical inventory of 20 medical supply line items disclosed that GIP overstated the total quantity of the sampled items on hand by 657 units and the value by $14,187 (101 percent). GIP reported that that there were 1,361 units of the 20 medical supply line items in stock with a value of $28,220. However, we found only 704 units of the medical supply line items with a value of $14,033 during our physical inventory. Subsequently, the GIP inventory records for 16 of the 20 medical supply line items we reviewed were inaccurate. For 14 of the 20 items, GIP records overstated the number of units in inventory by 673 units and their value by $14,297, and for the remaining 2 items the inventory was understated by 16 units and $110.

Without accurate inventory records, Support Services and FMS managers cannot readily establish supply reorder points and maintain appropriate stock levels. Consequently, inaccurate inventory records can also lead to unexpected overages or shortages of critical supplies that affect the efficient and timely delivery of quality health care services.

Inventory Monitoring. Support Services and FMS managers needed to correct inaccuracies in GIP inventory data, and to use GIP and PIP to monitor supply usage and inventory levels to ensure compliance with VHA's 30-day supply goal. Based on available GIP inventory data, 15 of the 20 medical supply line items sampled had inventory levels in GIP ranging from 73 days to over 5,500 days stock on hand. The value of the sampled supplies that exceeded the 30-day supply goal was $9,383, or 66 percent of the $14,033 medical supply stock on hand. In addition, 6 of the 10 prosthetics supply line items in PIP had inventory levels ranging from 42 to 160 days. The value of the prosthetics supplies that exceeded the 30-day goal was $1,528, or 38 percent of the $3,960 prosthetics supply stock on hand that we sampled.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Healthcare System Director requires: (a) FMS staff correct unit-of-issue conversions and inventory balances, and record all inventory transactions in GIP; and (b) Support Services and FMS managers use GIP and PIP to monitor and adjust medical and prosthetics supply inventory levels to comply with the 30-day supply goal.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that the unit-of-issue conversions have been corrected and future conversions will be initiated as items are ordered. FMS staff will conduct bi-annual, wall-to-wall inventories to ensure that GIP is accurate, as well as monthly spot-checks of GIP to ensure that staff are using the system to record all inventory transactions. In addition, inventory levels will be adjusted to come into compliance with

the 30-day supply level goal. FMS staff have received GIP training and VA Central Office is coordinating additional training. Monthly reports will be run to ensure accuracy of conversion factors and identify excess stock to ensure that 30-day stock levels are maintained. We will follow up on the planned actions until they are completed.

Bulk Oxygen Utility System – Monitoring, Delivery, and Refill Procedures Needed Improvement

Conditions Needing Improvement. Healthcare system managers needed to provide better oversight over the healthcare system's bulk oxygen utility system. On April 5, 2004, VHA issued a Patient Safety Alert (PSA) in response to incidents at two facilities where oxygen utility system services were disrupted because alarms on the main oxygen tanks did not activate until they were near or completely empty. The PSA also noted that the two facilities did not meet a National Fire Protection Association (NFPA) code that required the system's alarms to be annunciated in two independent areas that were continuously attended and monitored by qualified and trained staff. Subsequently, the PSA listed several action items that all VHA healthcare facilities were required to complete by April 30, 2004. There have been no adverse oxygen system incidents reported at the healthcare system, but two areas needed improvement to comply with PSA requirements.

Bulk Oxygen Alarm Monitoring Stations. The healthcare system had two independent monitoring stations. However, only one was continuously attended and monitored as required. To address this deficiency until the healthcare system could fully comply with the NFPA code, the healthcare system's Interim Life Safety Measures (ILSM) plan required VA police to check the alarm status at the second monitoring station every 2 hours and document these checks on a log sheet.

We did not find evidence that the VA police performed the alarm status checks required by the ILSM plan. Once we identified this deficiency, healthcare system managers corrected the problem and provided us with an acceptable correction plan. Healthcare system managers told us that the oversight occurred because of poor communication between VA police and FMS staff. FMS staff planned to relocate the monitoring station to the boiler room where it could be continuously attended and monitored by qualified and trained staff.

Bulk Oxygen Delivery and Refill Procedures. The PSA required the facilities to ensure that qualified and trained technical staff monitored bulk oxygen refill procedures. As a result, the healthcare system developed a standard operating procedure for the bulk oxygen utility system that identified several FMS staff who were trained and authorized to monitor the delivery and refill of bulk oxygen tanks. We found that on two occasions, unauthorized FMS warehouse staff signed for deliveries and failed to notify the FMS staff responsible for monitoring the refill process. Healthcare system managers told us that FMS warehouse staff were not aware of the new delivery and refill monitoring

procedures. During the CAP review, the Chief, FMS issued a memorandum to all FMS staff that clearly identified staff who were trained and authorized to accept bulk oxygen deliveries and monitor the refill process.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Healthcare System Director requires: (a) healthcare system managers relocate the bulk oxygen monitoring station to the boiler room and ensure compliance with the ILSM plan until the move is completed, and (b) healthcare system managers implement and enforce the healthcare system's plan to ensure proper bulk oxygen delivery and refill procedures.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that ILSM procedures were maintained until the bulk oxygen monitoring station was installed and tested in the boiler room. The boiler plant staff have been trained, and a new standard operating procedure for responding to alarm activation is in place. In addition, training has been provided to FMS staff responsible for overseeing oxygen delivery and refill procedures. Physical security has been improved and signage has been added to ensure that drivers contact the appropriate staff when making deliveries. We will follow up on the planned actions until they are completed.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. FMS managers needed to improve inventory controls to ensure adequate accountability for nonexpendable equipment (items costing more than $5,000 with an expected useful life of more than 2 years, or that are classified as sensitive in nature). At the healthcare system, FMS staff are responsible for coordinating EIL physical inventory counts and updating EIL records. Designated healthcare system staff are required to perform physical inventory counts and report excess and transferred equipment to FMS.

To determine if equipment inventory controls were effective, we reviewed VHA and healthcare system policies and procedures, EILs, a judgment sample of 30 equipment items, delinquency notices, and the *Reports of Survey* for missing equipment. We identified three deficiencies that needed to be addressed.

Timeliness of EIL Inventories. VHA policy requires that an EIL inventory be completed within 10 days after receipt of the notice to conduct a physical count of the listed nonexpendable property, or 20 days if the EIL contains 100 or more line items. Although we found that all 52 EIL inventories had been completed, only one EIL was signed within the prescribed time frames. FMS staff sent delinquent notices to those officials who had not submitted signed EILs within 1 week of the due date. However, completion of the delinquent EILs ranged between 3 and 137 days after the due dates.

Sensitive Property. VHA policy requires that equipment items that are below $5,000 in acquisition value, but by their nature are subject to theft, loss, or conversion for personal use, be classified as sensitive property and be inventoried in the same manner as other nonexpendable equipment items. Laptops and other computer equipment are considered sensitive property. Our review of a judgment sample of 30 sensitive items showed that 6 laptop computers, 1 handheld computer, and 3 digital cameras had not been included on EILs.

EIL Accuracy. VHA policy requires quarterly spot checks of EILs to verify inventory accuracy. VHA policy also requires that if EIL inventory accuracy rates fall below 95 percent, the next EIL inventory should be performed within 6 months. We determined that the FMS staff performed monthly, instead of quarterly spot checks, to verify EIL inventory accuracy. However, we found that FMS staff only checked medical equipment and did not include other types of equipment, such as computers, when they verified the accuracy of EILs. Furthermore, during our physical inventory of the 30 sensitive items discussed above, 4 of the 30 items valued at $89,244 could not be located. In addition, 28 of the 30 items had incorrect location information recorded in the inventory system. We also noted that 5 of the 52 EILs had inventory accuracy rates below 95 percent, but the next inventories had not been scheduled within the prescribed 6-month timeframe. Subsequent to our physical inventory, FMS staff located 1 of the 4 missing items and generated *Reports of Survey* for the 3 remaining items valued at $73,369.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Healthcare System Director requires: (a) FMS staff ensure that EIL inventories are completed in a timely manner, (b) FMS staff record all sensitive property on EILs, (c) FMS staff expand its periodic checks to include a cross-section of equipment items from each EIL, and (d) FMS staff ensure that equipment locations are routinely updated on EILs and follow-up inventories are conducted within 6 months if an EIL's inventory accuracy rate falls below 95 percent.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that a process is in place to ensure that EIL inventories are done in a timely manner. FMS staff will evaluate EILs to make sure that sensitive equipment is included on an inventory listing. FMS staff will perform quarterly spot checks of EIL records in accordance with VHA policy. During the quarterly spot checks, FMS staff will update equipment locations as needed and follow-up inventories will be initiated within 6 months for any EIL that falls below the 95 percent accuracy rate. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Needed To Be Strengthened

Conditions Needing Improvement. The Acting Fiscal Service Manager and the Government Purchase Card Coordinator (PCC) needed to strengthen internal controls over the Government Purchase Card Program. We reviewed purchase card usage from October 1, 2003, through May 31, 2004, and found no questionable transactions. In addition, we found that key duties were segregated, appropriate training was provided, cardholders had appropriate procurement warrants, cardholders reconciled purchases in a timely manner, and purchases were being monitored. However there were three areas where controls over the Government Purchase Card Program could be strengthened.

Evidence of Monthly Audits. VHA policy requires facilities to monitor their Government Purchase Card Programs and perform monthly purchase card audits to identify potential problems in the administration of the program. We found that the healthcare system had implemented a purchase card program audit process, but there was no evidence that audits had been completed for the months of April and May 2004. The Acting Fiscal Service Manager stated that a lapse in the purchase card audit process occurred due to the resignation of the PCC in May 2004.

Timeliness of Certifications. VA policy requires cardholders to reconcile purchases and purchase card statements within 10 working days of the receipt of the monthly statements and forward reconciliations to approving officials for review. The approving officials must then review and certify the reconciliations and forward them to the billing officer within 14 working days. We found that 12 of the 186 (6.5 percent) reconciliations sampled were reviewed and certified between 26 and 231 days and the PCC had not adequately monitored the certification process to ensure they were timely.

Purchase Card Cancellation. VA policy requires the PCC and Fiscal Service Manager to account for and deactivate purchase cards at the time employees separate from a VA facility. However, we could not verify when the purchase cards of 10 separated employees, who left the healthcare system between January 2002 and May 2004, were deactivated. The PCC and Acting Fiscal Service Manager informed us that the purchase cards had been deactivated, but the healthcare system did not have any documentation showing that the purchase cards had been retrieved and deactivated.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Healthcare System Director requires: (a) the PCC perform and document the completion of the required monthly Government purchase card audits, (b) approving officials certify purchase transactions within 14 working days, and (c) the PCC and Acting Fiscal Service Manager document the retrieval and deactivation of Government purchase cards when employees separate from the healthcare system.

The VISN and Healthcare System Directors agreed with the findings and suggestions and reported that the PCC is performing the monthly Government purchase card audits. The PCC is monitoring the *Unapproved Reconciliation* report on a weekly basis to ensure that approving officials are certifying transactions as required, and follow-up procedures are in place to identify transaction reconciliations that exceed the 14-day time limit. In addition, procedures have been implemented to document the retrieval and deactivation of Government purchase cards at the time employees separate from the healthcare system.

Information Technology Security – Security Controls Needed Improvement

Conditions Needing Improvement. VHA policy requires that physical devices and control measures be used to protect information technology (IT) assets and sensitive information from misuse and damage in the event of accidents, fires, power outages, environmental hazards, or malicious acts. Accordingly, VHA has implemented controls related to IT access, data security, and computer virus protection. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, or misuse.

Information Resources Management (IRM) Service staff implemented procedures to ensure IT users had the appropriate computer privileges. Recently hired employees received computer security awareness training, and experienced employees received annual refresher training. Password controls and virus protections were in place. Alternate processing sites had been designated, and critical information was backed up and stored at a secure offsite location. Policies were in place to ensure sensitive information was removed from computers prior to disposal, and a comprehensive continuity of operations plan outlined disaster recovery and contingency procedures. However, we identified two areas where IRM Service managers could improve IT security and compliance with VHA policy.

System Access. IRM Service managers did not ensure Local Area Network (LAN) and VistA access privileges of separated employees were terminated in a timely manner. VA policy requires facilities to terminate access privileges when employees separate from the healthcare system. The healthcare system's VistA Security Plan required service chiefs, automated data processing applications coordinators, or supervisors to ensure access privileges of separated employees were terminated by IRM Service staff. However, we found that 63 of the 420 (15 percent) staff with LAN and VistA access who had separated from the healthcare system by May 2004 still had access privileges.

Internet Monitoring. The Information Security Officer (ISO) had not established specific time schedules for monitoring and auditing the use of Internet usage by employees. Improper Internet usage by employees can lead to unauthorized users gaining access to VA information systems, loss in productivity, increased network costs, and the

investment of significant resources to correct related system and network configuration problems. Although IRM Service managers had established adequate policies and procedures to limit access to the Internet through the healthcare system's computers, these policies did not include procedures to ensure the timely monitoring of Internet usage. The ISO did not monitor Internet usage from November 2003, until May 2004, because the Internet Monitoring System was not operational during this period.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Healthcare System Director requires: (a) IRM Service staff to promptly terminate system access for separated employees, and (b) the ISO to establish and implement procedures to ensure timely monitoring of Internet usage.

The VISN and Healthcare System Directors agreed with the findings and suggestions and reported that procedures are in place to ensure that system access is terminated for separated employees. In addition, Internet monitoring will be conducted on a quarterly basis, and reports will be forwarded to the Healthcare System Director and Associate Healthcare System Director for appropriate follow up with individual employees.

Controlled Substances Accountability – Controls Needed to be Strengthened

Conditions Needing Improvement. VHA policy requires Pharmacy Service staff to manage medications, particularly controlled substances, to ensure patient safety and prevent diversion. Each facility is required to have a controlled substances inspections program to certify the accuracy of records and inventory. In addition, VA policy requires specific physical safeguards to ensure pharmacy security. To assess controlled substances management controls and pharmacy security, we interviewed Pharmacy Service staff, the Controlled Substances Coordinator (CSC), and controlled substances inspectors; inspected controlled substances storage areas; and reviewed pharmacy procedures. We also observed an unannounced controlled substances inspection conducted in an inpatient ward and an outpatient clinic. We identified three areas where Pharmacy Service managers could improve controlled substances accountability.

Medication Management Controls. VHA policy requires Pharmacy Service staff to conduct inventories of controlled substances every 72 hours and document, investigate, and determine the cause of any identified discrepancies. Our review of the pharmacy inventory records showed that from February to April 2004, Pharmacy Service staff performed all required inventories. However, we could not ensure that all of the inventories were properly conducted or that all identified discrepancies were resolved because of inadequate inventory documentation.

Although we found no indications of diversion, our review of the inventory records disclosed 55 discrepancies that were not clearly resolved. For 7 of the 55 discrepancies, inspectors had not consistently marked the inventory control sheets so that we could

verify that the inspections had been conducted properly and that inventory accounts had been reconciled. For 21 of the discrepancies, Pharmacy Service staff used controlled substances receiving reports and daily activity logs as support for reconciliations of the discrepancies. However, in our opinion, the information and documentation provided were not sufficient to clearly resolve the identified inventory discrepancies. Finally, the remaining 27 discrepancies had supporting documentation that was sufficient to resolve the identified discrepancies, but the disposition had not been recorded on the inventory control sheets as required by VHA policy.

Controlled Substances Inspection Training. VHA policy requires healthcare facilities to maintain controlled substances inspection programs and controlled substances inspectors to attend a nationally mandated controlled substances inspection training program. Although the inspectors had attended the national training program, they experienced difficulties conducting the unannounced inspections at the healthcare system. During our observation of the unannounced inspections, the inspectors were unsure as to how they should fill out healthcare system inspection checklists and had problems conducting an inventory of controlled substances stored in Pyxis machines.

Unannounced Controlled Substances Inspections. VA policy requires healthcare facilities to conduct monthly unannounced controlled substances inspections for all wards and storage areas containing controlled substances and to review documentation related to the receipt and inventory of controlled substances. We determined that the healthcare system performed the monthly inspections during the period May 2003 to June 2004. However, the inspections did not include the review of 72-hour inventories and receiving reports for the inspected areas. The CSC implemented corrective action in May 2004 to revise the inspection process and correct this deficiency.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Healthcare System Director requires: (a) Pharmacy Service staff establish procedures to properly identify, document, and resolve discrepancies noted during the 72-hour inventories, (b) the CSC provides local training to inspectors on how to perform controlled substances inspections, and (c) the CSC ensures the review of 72-hour inventories and receiving reports during the monthly controlled substances inspections.

The VISN and Healthcare System Directors agreed with the findings and suggestions and reported that Pharmacy Service managers have reinforced the need to follow the controlled substances inventory standard operating procedures for the 72-hour inventories and that Pharmacy Service managers will conduct monthly reviews of the 72-hour inventories to ensure compliance. The CSC will conduct controlled substances inspector training every 2 months at the healthcare system. In addition, the requirement for the 72-hour inventories has been added as a line item on the inspector's checklist for controlled substances inspections. The CSC will accept the monthly inspection reports only after a review to ensure that all checklist items have been completed.

Agent Cashier – Controls Needed To Be Strengthened

Conditions Needing Improvement. VA policy provides healthcare facilities with procedures for performing unannounced audits of the Agent Cashier's advance funds and undeposited collections, and a formula for determining the Agent Cashier turnover rate. We reviewed Agent Cashier controls to determine if controls adequately protected funds from fraud, waste, or abuse. We determined that Agent Cashier cash boxes, equipment, and work areas were adequately safeguarded; the Healthcare System Director had custody of safe combinations and duplicate keys to the Agent Cashier work areas and cash boxes; and responsibility and accountability for the Agent Cashier function had been transferred to the Alternate Agent Cashier for a 2-week period during the last calendar year in accordance with VA policy. However, there were two areas where Fiscal Service managers could improve Agent Cashier controls.

Unannounced Audits. VA policy requires that unannounced audits be conducted every 90 days on a random schedule to ensure Agent Cashier staff can not predict when the audits might occur. Our review of the last four unannounced audits indicated that they had been performed during the same months during FYs 2003 and 2004. We also determined that the audits had been conducted at intervals ranging between 120 and 210 days.

Turnover Rate. VA policy requires staff who perform the Agent Cashier audits to rotate so that the same staff do not always complete the unannounced Agent Cashier audits. As part of the unannounced audits, Agent Cashier auditors are required to review the last three consecutive monthly cash disbursements and to apply a turnover rate formula to determine if the amount of the Agent Cashier cash advance is appropriate. During the period January 2003 through May 2004, only 1 of the 4 Agent Cashier auditors used the correct turnover rate formula and found that Fiscal Service needed to reduce the Agent Cashier's cash advance from $12,000 to $9,250. During the unannounced audit conducted during the CAP review, the Agent Cashier auditor used the proper turnover rate formula and determined that the current $9,250 cash advance was still appropriate.

Suggested Improvement Action. We suggested that the VISN Director ensures that the Healthcare System Director requires: (a) Fiscal Service staff to conduct timely unannounced Agent Cashier audits at random intervals in accordance with VA policy, and (b) Agent Cashier auditors use the proper turnover rate formula during unannounced Agent Cashier audits and ensure that the cash advance is adjusted accordingly.

The VISN and Healthcare System Directors agreed with the findings and suggestions and reported that the Healthcare System Director has taken measures to ensure that the unannounced audits are conducted in a timely and random manner. In addition, instructions regarding the calculation of the turnover rate have been placed in the audit file for the Agent Cashier auditors to follow to ensure compliance, and a monthly review will be performed to ensure that the proper turnover rate has been applied.

Appendix A

VISN 21 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 30, 2004

From: VISN 21 Director

Subject: VA Central California Healthcare System Fresno, CA

To: Director, Los Angeles Audit Divisions (52LA)

I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of the VA Central California Health Care System (VACCHCS). I carefully reviewed the report, as well as my notes for the exit briefing on June 25, 2004. In addition, I discussed the findings and recommendations with senior leadership at VACCHCS and the VISN 21 office.

In brief, I concur with all of the conditions needing improvement and recommended/suggested improvement actions. The implementation plan showing specific corrective actions is provided in Appendix B. As you will note, the vast majority of the actions have already been completed and the remainder are ongoing.

I am pleased that there are no "negative" findings related to environment of care, part-time physicians, quality management program and service contracts. I am very proud that questionnaires and patient interviews documented a high level of patient satisfaction.

In closing, I would like to express my appreciation to the CAP review team. The team members were professional and comprehensive. The educational sessions regarding fraud and abuse awareness were also helpful and well received. The collective efforts and insights of the CAP review team have helped to improve our clinical and business practices at VACCHCS.

(original signed by:)
Robert L. Wiebe, M.D., M.B.A.

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 26, 2004

From: Healthcare System Director

Subject: **VA Central California Healthcare System Fresno, CA**

To: Director, Los Angeles Audit Operations Divisions (52LA)

THRU: Director, VISN 21 Sierra Pacific Network (10N21)

I wish to thank the OIG CAP Survey Team for their professional, thorough, fair and instructive survey June 21-25, 2004. I concur with the findings and recommendations. Most corrective actions are, in fact, either complete or very near completion.

I'm very pleased surveyors did not have "concerns" in nine areas including Environment of Care, Patient Care Units and Quality Management. The staff is also quite proud that 100% of patients surveyed by the OIG rated overall care to be "Excellent, Very Good, or Good."

We are also very proud that VA staff assisted Surveyors in developing and testing the OIG's new "Pressure Ulcer" and "Iraqi Veterans" survey methodology although these accomplishments were not cited in this report, we were honored to be selected in this important effort.

Again, my thanks to the OIG Team, for their comprehensive survey. This joint effort continuously monitors and raises the level of care and service provided to the nation's veterans.

(original signed by:)

Alan S. Perry, FACHE
Director

Cc: Director, Management Review Office (10B5)

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensures that the Healthcare System Director requires: (a) MCCF staff verify insurance information for all veterans with unidentified insurance, (b) the MCCF Coordinator develops and implements monitoring procedures to ensure that bills are issued promptly, and (c) clinicians record complete and timely documentation in the medical records.

Concur **Target Completion Date:** Complete

a) MCCF staff verifies insurance information for all veterans with unidentified insurance

IMPLEMENTATION PLAN: ***A refresher training of patient registration staff throughout the facility was conducted June 9 and 17, 2004, as indicated. Continued education and emphasis on insurance collection and verification is ongoing by BAS managers. A recent comparison showed a 70% increase for July insurance buffer entries over the entries in May 2004. Additionally, patient registration staff e-mail to the MCCF staff information that cannot be placed into the insurance buffer file, such as cancelled, termed or wrong insurance information.***

Other improvements include Pre-Registration staff training on how to annotate "no" insurance coverage in the Pre-Registration software. MCCF inpatient insurance staff has created a process to ensure late entry for of insurance information for inpatients is verified with the insurance company upon entry (vs when the insurance buffer file is worked).

Quarterly educational events will be held in September, December, March, and June regarding insurance verification. This will ensure staff (both old and new) remains focused on the importance of insurance verification. Monitoring will take place utilizing the insurance buffer file employee report quarterly. Those employees with less than a 20% increase in insurance identification and those employees not meeting the average insurance collected by their peers will receive spot-training.

b) The MCCF Coordinator develops and implements monitoring procedures to ensure that bills are issued promptly

IMPLEMENTATION PLAN: ***The billing project implemented in early June continues at this time. Current statistics indicate 63% of the bills reported on the Unbilled Report pulled by IG have been cleared. Billing staff productivity statistics for period June 15 through July 31 indicate a 44% increase in bills produced (49% in dollar value) over the period prior to the billing project implementation, April 15 through May 31, 2004.***

We have implemented Class III software enabling us to capture all unbilled events based on a multitude of factors, including capturing events close to the filing timeframes. This has significantly reduced the manpower required to ensure billable events are captured and billed prior to expiration of the filing timeframe.

The MCCF Coordinator has received a listing of candidates for the billing vacancy, interviews have been conducted, and a selection made.

MCCF Coordinator will run the unbilled report on the 15th of each month and review the events that have not been billed. These events will be sorted by age and given to billing for creation or cancellation when appropriate (assigning a reason not billable).

Billing productivity reports will be monitored weekly by MCCF Coordinator. Thresholds will be based on the complexity of the biller's assignments. The mid-level goal will be 100 bills per day. Feedback will be provided to the biller weekly. If the biller is under the threshold for two consecutive weeks, he/she will be provided additional training. If the employee continues to not meet the threshold, disciplinary actions will be taken as appropriate.

Additionally, bi-weekly monitors will be in place to ensure provider documentation does not delay or result in a non-billable event. Focus will be on immediate turn around of those events having either no documentation or insufficient documentation. **IT IS IMPORTANT TO NOTE THAT VA IS ALLOWED TO GO BACK IN TIME AND CREATE BILLS FOR PAST EVENTS IN THE EVENT A PATIENT ACQUIRES HEALTH INSURANCE**. ***This may cause the billing statistic to be falsely skewed.***

c) Clinicians record complete and timely documentation in the medical records

IMPLEMENTATION PLAN: We have implemented several new processes to meet this recommendation. A review of all Deliverex-rejected encounters for missing medical documentation is conducted. Providers are contacted to complete the missing documentation within a 2-3 week period. In an event provider does not respond, personal contact is made with the provider/service.

Provider-specific documentation training is ongoing; Imaging Service radiologists have been provided this training and we anticipate an increase in the number of high-dollar billable events from radiology. The revenue cycle staff has received training and education on the proper use and selection of "claims tracking non-billable reason".

A new local audit was implemented to generate and review the Reason Not Billable report for potential deficiencies in provider documentation.

A Reasons Not Billable Report generated for period June 15-July 15 showed a 30% decrease in the number of non-billable events due to no documentation or insufficient documentation over the period April 15-May 15, 2004.

The reason-not-billable report will be run bi-weekly to identify newly marked reasons not billable. Providers will be contacted to provide documentation. Providers who fail to provide documentation for the same event on two consecutive reports will receive notification along with their service chief. Those providers who fail to provide documentation for the same event on three consecutive reports will be turned over to the Chief of Staff for follow-up. Consistent failure to document medical care may be taken into consideration during annual re-privileging.

The reason-not-billable report will be generated quarterly to ensure the overall percentage of events marked no documentation or insufficient documentation decreases by at least 20% per quarter. The report will also be analyzed by specialty to target specific areas needing training/education by comparing the number of overall non-billable reasons to the number for a specialty. Based on the specialty report, a reason not billable report for individual providers will be run to target those providers with the highest percentage of cases. Again, those providers will be targeted for education and training. The target improvement will be 20% decrease in the overall number of events marked not billable due to no documentation or insufficient documentation over the same period for the prior year. Results of this report will be provided to the Chief of Staff on a quarterly basis.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Healthcare System Director requires: (a) FMS staff correct unit-of-issue conversions and inventory balances and record all inventory transactions in GIP, and (b) Support Services and FMS managers use GIP and PIP to monitor and adjust prosthetic and medical supply inventory levels to comply with the 30-day supply goal.

Concur **Target Completion Date:** Complete/Ongoing

(a) FMS staff correct unit-of-issue conversions and inventory balances and record all inventory transactions in GIP.

IMPLEMENTATION PLAN: ***Unit-of-issue conversions have been corrected on the 3 items found during the survey. Additionally, FMS has initiated a continuing effort to find and correct these conversion factors as items are ordered.***

FMS will develop a monthly top 50 items used in SPD and will work through that list to ensure that Unit-of-issue is correct. In addition, they will continue to stress the importance of recording inventory transactions in GIP. FMS will conduct bi-annual wall-to-wall inventories to ensure that the GIP is accurate. These Inventories will be conducted in December and June of each year. Finally, Monthly spot-checks of GIP usage will ensure that staff are using the system to record all inventory transactions.

(b) Support Services and FMS managers use GIP and PIP to monitor and adjust prosthetic and medical supply inventory levels to comply with the 30-day supply goal.

IMPLEMENTATION PLAN: ***Inventory Levels have been, and continue to be, adjusted to come into compliance with the 30-day supply level as directed by VA policy. The GIP was implemented only a year ago at this facility and reducing the stock on hand has been an ongoing process. The staff at this facility has only recently received detailed training on how to manage items in the system, and Central Office is coordinating additional training. This measure is expected to continue to improve over the next year***.

A report of inactive and over-stock items will be run monthly and items identified will be reviewed to ensure accuracy of conversion factors. Any excess stock will be flagged for non-reorder, until stock achieves the appropriate level.

Prosthetics will utilize the PIP 30 day inventory report to ensure 30 day stock levels are maintained. Copies of monthly reports are maintained on file.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Healthcare System Director requires: (a) healthcare system managers relocate the bulk oxygen monitoring station to the boiler room and ensure compliance with ILSM procedures until the move is completed, and (b) healthcare system managers implement and enforce the healthcare system's plan to ensure proper bulk oxygen delivery and refill procedures.

Concur **Target Completion Date:** Complete

(a) healthcare system managers relocate the bulk oxygen monitoring station to the boiler room and ensure compliance with ILSM procedures until the move is completed

IMPLEMENTATION PLAN: The ILSM procedures were maintained, until the additional bulk oxygen monitoring station was installed and tested in the Boiler Plan on August 13th. (copies of logs reflecting the 2 hour checks by VA Police are available upon request). Once the alarm panel was installed and tested the need for the ILSM was negated. In addition, Boiler plant staff has been trained and an SOP for responding to alarm activation is in place.

(b) Healthcare system managers implement and enforce the healthcare system's plan to ensure proper bulk oxygen delivery and refill procedures.

IMPLEMENTATION PLAN: ***Additional training has been provided to FMS staff responsible for overseeing bulk oxygen delivery and refill procedures. Access to the area is more tightly controlled by eliminating contractor's key access. In addition, a matrix has been developed that is completed at each delivery of medical gas. This matrix is signed by the appropriately trained individual and is kept on file to ensure that the process has been followed. Medical gas contractor has been notified, and all drivers have been trained. In addition, signage has been placed to ensure that drivers contact appropriate personnel for deliveries.***

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Healthcare System Director requires: (a) FMS staff ensure that EIL inventories are completed in a timely manner, (b) FMS staff record all sensitive property on EILs, (c) FMS staff expand its periodic checks to include a cross-section of equipment items from each EIL, and (d) FMS staff ensure that equipment locations are routinely updated on EILs and follow-up inventories are conducted within 6 months if an EIL's inventory accuracy rate falls below 95 percent.

Concur **Target Completion Date:** Complete/Ongoing

(a) FMS staff ensure that EIL inventories are completed in a timely manner

IMPLEMENTATION PLAN: ***FMS staff will provide an e-mail following delivery of the hard copy of all EIL inventory requests. The e-mail will be copied to the Program Director, FMS and to the facility Associate Director for follow-through. The Associate Director's Office will suspense the response to insure that these are handled in a timely fashion. Individuals who fail to comply with the follow-up actions and complete the inventory timely will be referred to the Associate Director for appropriate action.***

(b) FMS staff records all sensitive property on EILs

IMPLEMENTATION PLAN: ***FMS will evaluate each EIL as it is prepared for issue to consider all equipment for inclusion as sensitive property (i.e. laptop computers, digital cameras, and similar electronic portable equipment under***

the $5,000 threshold). These items will be added through the year as each EIL comes up monthly. Each completed EIL will be maintained for review.

(c) FMS staff expand its periodic checks to include a cross-section of equipment items from each EIL,

IMPLEMENTATION PLAN: ***As per VA Handbook part 4 section 5302.3 "...Verification of inventory accuracy will be accomplished by quarterly spot-checks of EIL records. Spot checks will be conducted by the responsible official, or designee, and AMMS (FMS)." FM will conduct quarterly checks in accordance with this policy. Documentation will be available upon request.***

(d) FMS staff ensure that equipment locations are routinely updated on EILs and follow-up inventories are conducted within 6 months if an EIL's inventory accuracy rate falls below 95 percent.

IMPLEMENTATION PLAN: ***During quarterly checks of equipment, Property Management will routinely update the locations of equipment. Additionally, Property Management will initiate follow-up inventories within 6 months for any EIL that reports less than a 95% accuracy rate. Documentation will be available upon request.***

OIG Suggestion(s)

Suggested Improvement Action. We suggest that the VISN Director ensure that the Healthcare System Director requires: (a) the PCC perform and document the completion of the required monthly Government purchase card audits, (b) approving officials certify purchase transactions within 14 working days, and (c) the PCC and Fiscal Service Manager document the retrieval and deactivation of Government purchase cards when employees separate from the facility.

Target Completion Date: Complete

(a) The PCC perform and document the completion of the required monthly Government purchase card audits,

IMPLEMENTATION PLAN: ***Monthly reports are being completed as required. Reports are filed monthly and are available for review. Reports are provided to the Associate Director on a quarterly basis.***

(b) Approving officials certify purchase transactions within 14 working days, and

IMPLEMENTATION PLAN: ***The PCC will monitor the unapproved reconciliation report on a weekly basis to insure that the approving officials certify transactions as required. Those approving officials with transactions exceeding 14 days, will receive an email showing those purchases that are non-compliant, and will be asked to rectify this within 48 hours. Individuals who fail to rectify transactions within 14 days on more than two instances, will be referred to their Supervisor and Service Chief for appropriate education and action. Continued lack of compliance will lead to Purchase Card deactivation.***

(c) The PCC and Fiscal Service Manager document the retrieval and deactivation of Government purchase cards when employees separate from the facility.

IMPLEMENTATION PLAN: ***Government Purchase Cards will be included as a stop on the required paperwork (check-out sheet) when employees leave and clear station. The card will be destroyed by the PCC at that time, in the presence of the card holder. The card holder will then sign a document that they witnessed that the card was deactivated in the computer.***

Suggested Improvement Action. We suggest that the VISN Director ensure that the Healthcare System Director requires: (a) IRM staff to promptly terminate system access for separated employees, and (b) the ISO establish and implement procedures to ensure timely monitoring of Internet usage.

Concur **Target Completion Date:** Complete/Ongoing

(a) IRM staff to promptly terminate system access for separated employees.

IMPLEMENTATION PLAN: ***A new policy has been developed which outlines requirements for 30 and 90 day checks on account inactivity. At 30 days of inactivity, Service Chiefs will be queried as to the continued need for a user's account. At 90 days, the account will be automatically deactivated, by IRM.***

HRM Service will forward terminated WOC employee information along with the terminated permanent employee information to the ISO and IRMS on a monthly basis. This will be compared to the report generated by IRM.

Monthly review of these reports will ensure that accounts are deactivated for separated employees and due to inactivity after 90 days.

(b) the ISO establish and implement procedures to ensure timely monitoring of Internet usage.

IMPLEMENTATION PLAN: ***Internet Monitoring will be conducted randomly on a quarterly basis. These reports will be forwarded to the Health Care System Director and Associate Director for appropriate follow-up with individual employees.***

Suggested Improvement Action. We suggest that the VISN Director ensure that the Healthcare System Director requires: (a) Pharmacy Service staff establish procedures to properly identify, document, and resolve discrepancies noted during 72-hour inventories, (b) the CSC provides local training to inspectors on how to perform controlled substances inspections, and (c) the CSC ensures the review of 72-hour inventories and receiving reports during the monthly controlled substances inspections.

Concur **Target Completion Date:** Complete

(a) Pharmacy Service staff establish procedures to properly identify, document, and resolve discrepancies noted during 72-hour inventories

IMPLEMENTATION PLAN: ***Pharmacy Service reinforced controlled substance inventory standard operating procedures to properly, identify, document, and resolved discrepancies noted during 72 hour inventory as noted in the SOP. Pharmacy Leadership will conduct monthly reviews of the 72 hour inventories to ensure compliance.***

(b) the CSC provides local training to inspectors on how to perform controlled substances inspections

IMPLEMENTATION PLAN: ***Inspector training will occur every two months in a meeting/classroom setting (implemented). E-mail group established for ongoing notification of changes/updates/ideas for improvements. Annual review of training, as well as the topics and questions discussed via email will be performed.***

(c) the CSC ensures the review of 72-hour inventories and receiving reports during the monthly controlled substances inspections.

IMPLEMENTATION PLAN: ***The requirement for 72 hour inventories has been added as a line item on the Inspector's checklist, in addition, inspectors have been educated, and finally the CSC accepts monthly inspection report only after review that all checklist items are completed. Monthly inspection reports are reported to the Medical Center Director.***

Suggested Improvement Action. We suggest that the VISN Director ensures that the Healthcare System Director requires: a) Fiscal Service staff to conduct timely unannounced Agent Cashier audits at random intervals in accordance with VA policy, and (b) Agent Cashier auditors use the proper turnover rate formula during unannounced Agent Cashier audits and ensure that the cash advance is adjusted accordingly.

Concur **Target Completion Date:** Completed

a) Fiscal Service staff to conduct timely unannounced Agent Cashier audits at random intervals in accordance with VA policy,

IMPLEMENTATION PLAN: ***The Director will ensure the unannounced audits will be conducted in a timely and random manner. This item has been placed in the suspense file and is acted upon a random number of days after the suspense comes up in the file.***

(b) Agent Cashier auditors use the proper turnover rate formula during unannounced Agent Cashier audits and ensure that the cash advance is adjusted accordingly.

IMPLEMENTATION PLAN: ***Instructions regarding the calculation of the turnover rate have been placed in the audit file for auditors to read/review and comply. Monthly review reveals that the appropriate calculation factor has been applied. Instructions are also included in the suspense listed above to ensure that the auditor uses the correct formula.***

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Increase in collections due to improved MCCF billing and documentation procedures.	$8,821

OIG Contact and Staff Acknowledgments

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Appendix E

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