Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, VA

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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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Introduction

During the week of August 23-27, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Hunter Holmes McGuire VA Medical Center (referred to as the medical center), which is part of the Veterans Integrated Service Network (VISN) 6. 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 168 employees.

Results of Review

This CAP review focused on 14 areas. As indicated below, there were no concerns identified in three of the areas. The remaining 11 areas resulted in recommendations for improvement.

The medical center complied with selected standards in the following areas:

- Government Purchase Card Program
- Pharmacy Security
- Quality Management

Based on our review, the following organizational strengths were identified:

- Deep Brain Implant Program for Parkinson's disease.
- Government purchase cards were effectively used and monitored.

We identified 11 areas which needed additional management attention. To improve operations, the following recommendations were made:

- Correct environment of care deficiencies.
- Properly document modifications to the bulk oxygen delivery contract.
- Improve moderate sedation policies and procedures.
- Obtain inventory scanning equipment needed to reduce supply inventory levels.
- Enhance Medical Care Collections Fund billings and collections.
- Cancel unneeded obligations.
- Establish accounts receivable timely and follow up on delinquent Federal accounts receivable.

- Improve information technology security.
- Strengthen accountability over controlled substances.
- Strengthen Contracting Officer's Technical Representative delegation and training.
- Ensure Means Test information is current.

This report was prepared under the direction of Mr. Nelson Miranda, Director, and Mr. Randall Snow, Associate Director, Washington, DC Regional Office of Healthcare Inspections.

VISN 6 and Medical Center Directors Comments

The VISN and Medical Center Directors concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 16 for the full text of the Director's comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Richmond, Virginia, the Hunter Holmes McGuire VA Medical Center is a tertiary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at a community-based outpatient clinic located in Fredericksburg, Virginia. The medical center is part of VISN 6 and serves a veteran population of about 200,000 in a primary service area that includes 52 independent cities and counties in Virginia and northern North Carolina.

Programs. The medical center provides medical, surgical, mental health, geriatric, spinal cord injury, and ambulatory care services. The medical center has 329 hospital beds and 98 nursing home beds. It also operates several regional referral and treatment programs, including the Spinal Cord Injury and Disease program, the Parkinson's Disease Research and Education Center, and a heart transplantation program. The medical center also has sharing agreements with Virginia Commonwealth University (VCU) School of Medicine and the Kenner Army Health Clinic at Fort Lee, Virginia.

Affiliations and Research. The medical center has an affiliation with VCU and its health science schools (Medicine, Nursing, Dentistry, Pharmacy, and Allied Health). In addition, the medical center is affiliated with an additional eight schools of nursing in the Richmond/Petersburg, VA area. Over 500 nursing trainees and nearly 400 medical students rotate through the medical center in a fiscal year. Through its major affiliation with the VCU Health System, the medical center participates in 30 distinct physician residency programs and supports 136 resident positions, through which over 400 residents rotate. Thirty additional affiliations exist for such fields as Technology (Radiology and Laboratory), Therapy (Occupational, Physical, Kinesiotherapy, and Audiology/Speech), Pharmacy, Social Work, and Dietetics. In Fiscal Year (FY) 2003, the medical center research program had 325 projects and a budget of $2.2 million. Important areas of research include Parkinson's disease, cholesterol metabolism, molecular oncology, and diabetes.

Resources. In FY 2003, medical care expenditures totaled $216 million. The FY 2004 medical care budget is $240 million, 11.1 percent more than FY 2003 expenditures. FY 2003 staffing was 1,811 full-time equivalent employees (FTE), including 129 physician and 334 nursing FTE.

Workload. In FY 2003, the medical center treated 38,432 unique patients, a 1.2 percent increase from FY 2002. The inpatient care workload totaled 6,755 discharges, and the average daily census, including nursing home patients, was 269. The outpatient workload was 338,478 visits. As of July 2004, the medical center had treated 36,407 unique patients, with an inpatient workload of 5,935 discharges and an outpatient workload of 318,107 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	Means Test Certifications
Bulk Oxygen Utility System	Medical Care Collections Fund
Contract Award and Administration	Moderate Sedation Practices
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Government Purchase Card Program	Supply Inventory Management
Information Technology Security	Unliquidated Obligations

The review covered facility operations for FY 2003 and FY 2004 through August 14, 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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 medical center employees, 174 of whom responded. We also interviewed 42 inpatients and 10 outpatients. The survey results were provided to medical center management.

During the review, we presented four fraud and integrity awareness briefings for medical center employees. These briefings, attended by 168 employees, covered procedures for

reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-15). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

Results of Review

Organizational Strengths

Advances in Treatment of End-Stage Parkinson's Disease. The medical center offers advanced therapy, called deep brain stimulation, to patients with Parkinson's disease. Parkinson's disease affects the brain centers that control muscular movements, and its symptoms include muscular tremors. The medical center has a multi-faceted program to treat the disease at its various stages. Neurosurgeons at the medical center treat the late stages of the disease with a pacemaker-like device implanted in the patient's chest that powers tiny electrodes placed deep in the brain. The neurosurgical team at the medical center is a leader in a national study that is comparing different locations in the brain for placement of the electrodes, to determine whether deep brain stimulation is superior to current drug therapies. So far, the results of the research and deep brain implant treatment are promising and have enabled patients to have significantly better control over their symptoms.

Government Purchase Cards Were Appropriately Used and Monitored. We reviewed the purchase orders for five purchase card charges totaling $99,128 for information technology and medical equipment. We found that the purchases were justified and appropriate. Also, we reviewed reconciliations and approvals for the year ending June 30, 2004, and found them to be appropriate and timely. We also verified that purchase cards of terminated employees were returned to the medical center as required.

Opportunities for Improvement

Environment of Care - Areas Needed Management Attention

Condition Needing Improvement. Veterans Health Administration (VHA) regulations require that the hospital environment present minimal risk to patients, employees, and visitors, and that infection control practices are employed to reduce the risk of hospital-acquired infections. We inspected inpatient units, outpatient primary care and specialty clinic areas, the operating room, the Supply Processing and Distribution area, the kitchen, and the grounds of the medical center. The following areas required management attention.

Cleanliness and Infection Control. Two patient rooms that were prepared for new admissions needed further cleaning of the furniture and bathrooms. Patient bathrooms in several clinics and inpatient wards were also in need of cleaning. Staff bathrooms and break rooms were dirty, with microwaves and refrigerators in need of cleaning. Nourishment kitchens on the inpatient units had dirty refrigerators and/or food left out in the open.

Patient Confidentiality. Federal law requires the safeguarding of sensitive patient information. Confidential patient information was found in two unattended offices in a Primary Care Clinic, and private patient information was displayed on two unattended computer screens in the Orthopedic Clinic and the Geriatrics and Extended Care Center.

Unsecured Prescription Pads. VHA policy states that VA prescription pads are to be secured. Prescription pads were found unsecured in desks drawers of three examination rooms inspected in the Geriatrics and Extended Care Center.

While we were onsite, managers took immediate steps to correct deficiencies, and the Medical Center Director submitted a plan of action to address the unresolved issues.

Recommended Improvement Action(s) 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) patient and staff areas are clean, (b) patient information is secured, and (c) prescription pads are secured.

The VISN and Medical Center Directors agreed with our recommendations; they also reported retraining of Environmental Management Section employees in methods and procedures for cleaning specific areas, biweekly reminders to staff to clean microwaves and refrigerators, and random physical inspections to monitor compliance with patient confidentiality regulations and prescription pad security. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Bulk Oxygen Utility System - Contract Modifications Not Properly Documented

Conditions Needing Improvement. A Contracting Officer's Technical Representative (COTR) did not document modifications to a national oxygen supply contract. The VA National Acquisition Center (NAC) had negotiated a contract for bulk oxygen supply with vendors nationwide. Each medical center participating in this contract is required to designate a COTR to be responsible for local contract administration.

To ensure that the oxygen supply is replenished when required, the COTR should document ordering and delivery instructions that are agreed upon with the vendor. This agreement is a modification to the national contract, and the NAC requires that the COTR forward a copy to the NAC.

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensure that the Medical Center Director requires that the COTR properly document modifications to the bulk oxygen utility system contract in a mutual agreement and send a copy to the NAC.

The VISN and Medical Center Directors concurred with the finding and recommendation and reported that the COTR and vendor have reached a mutual agreement and forwarded the modification to the NAC. We will follow up on the planned action until it is completed.

Moderate Sedation Practices - Managers Needed to Ensure Compliance with Moderate Sedation Policies and Procedures

Conditions Needing Improvement. Moderate sedation/analgesia is defined as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain an open airway, and spontaneous ventilation is adequate. The same anesthesia standards of care that apply in the operating room apply to areas outside of the operating room.

VHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that facility managers provide the same standard of care for a patient receiving moderate sedation throughout a facility. Patients in all care settings should receive comparable and acceptable quality of sedation/analgesia care, and anesthesiologists are required to help develop policies and procedures related to that care. VHA and JCAHO standards require that patients will have a pre-sedation assessment within 30 days of the procedure, which must include a review of medical, anesthesia, and medication histories; a history and physical examination; assignment of an American Society of Anesthesiologists classification; an anesthesia plan of care; and a discharge plan. An evaluation is also required immediately before the procedure.

Medical record documentation was not consistently maintained in accordance with VHA, JCAHO, and medical center policies.

- Pre-assessments performed by nursing staff in the Gastroenterology Clinic were not co-signed by a physician timely.
- Credentialing and Privileging files did not have evidence that physicians administering moderate sedation received the training required by medical center policy.
- Moderate sedation outcomes were not consistently reported to the Chief, Anesthesia Service for review and analysis.

Recommended Improvement Action(s) 3. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) pre-sedation assessments are co-signed by a physician timely, (b) clinicians complete required moderate sedation training, and (c) managers report all moderate sedation outcomes to the Chief, Anesthesia Service.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported plans to revise the moderate sedation form and policy to ensure documentation of physician pre-assessment of patients, physician completion of required training, and appropriate QM review. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management - Inventory Scanning Equipment Should Be Obtained to Reduce Inventory Levels

Condition Needing Improvement. Acquisition and Materiel Management (A&MM) Service employees needed to reduce excess supply inventories. VHA policy mandates that facilities use the Generic Inventory Package (GIP) to manage inventories and establish a 30-day stock level goal. GIP assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand.

As of June 30, 2004, inventory in primary control points consisted of 4,460 items valued at $1,538,086. To test the reasonableness of supply inventory levels, we reviewed a sample of 30 items valued at $66,355. For 24 of the 30 items reviewed (80 percent), the stock on hand exceeded 30 days of supply, with inventory levels ranging from 35 days to 2,755 days (over 7.5 years) of supply. For these 24 items, the value of stock exceeding 30 days supply was $37,197, or 56 percent of the total value of the 30 sampled items. Applying the 56 percent sample result to the total inventory of $1,538,086, we estimated that the value of excess stock to be about $860,000. According to the Chief, A&MM Service, supplies exceeded the 30-day level because the medical center did not have the scanning equipment needed to enter actual supply quantities from secondary supply points into GIP to automatically generate reorder quantities.

Recommended Improvement Action(s) 4. We recommend that the VISN Director ensure that the Medical Center Director obtains the scanning equipment needed to effectively manage supplies and reduce supply stock levels to meet the 30-day goal.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center received six inventory scanners and four barcode printers from the VISN on August 30; they completed training on October 26. Staff has reduced the sample inventory, which we identified as exceeding 30 days, by 25 percent. The improvement actions taken so far are acceptable, and we will follow up until they are completed.

Medical Care Collections Fund - Improved Procedures Could Increase Cost Recoveries

Condition Needing Improvement. The medical center increased Medical Care Collections Fund (MCCF) collections from $12.7 million in FY 2002, to $17.6 million in FY 2003, but was $2.8 million short of its collection goal of $20.4 million. As of June 24, 2004, the medical center had collected $15.8 million for FY 2004, which was on target for its $20.4 million goal. However, VISN management could further improve MCCF program results by:

- Strengthening billing procedures for fee-basis care.[1]
- Issuing bills for outpatient care related to inpatient stays.
- Contacting veterans and their employers to determine if the veterans have insurance.
- Training attending physicians to document care provided and supervision of residents in the medical records, and training coding staff to make correct decisions as to whether or not care is billable.

VISN 6 has consolidated all MCCF third party billings at the Central Revenue Unit (CRU), located at the VA Medical Center Asheville, North Carolina. However, medical center staff are still responsible for coding all care provided at their facility. After coding the care provided, billing information is forwarded to the CRU, where third party bills are issued to the insurance providers for fee-basis claims.

The clinic of jurisdiction (COJ) approves fee-basis care and sends the information to the VA Medical Center Salem, Virginia, where the fee-basis files are maintained and, following completion of the care, pays the medical providers. The fee-basis information should be provided to the CRU for veterans with potentially billable health care.

We found additional billing opportunities totaling $72,124, with estimated collections of $20,195.

[1] Fee-basis care is medical care provided to veterans by non-VA providers. VA reimburses the non-VA providers for the care.

VA Fee-basis Care. During the period October 1, 2003, to March 31, 2004, the medical center paid 2,339 fee-basis claims totaling $362,800 to non-VA medical providers who provided medical care to patients with health insurance. Payments included claims for inpatient care, outpatient care, and ancillary services. To determine whether the fee-basis care was billed to patients' insurance carriers, we reviewed a judgment sample of 15 claims totaling $149,853. Of these 15 claims, 7 were not billable to the insurance carriers, either because the fee-basis care was for service-connected conditions, the patient did not have insurance coverage on the date of service, or the services provided were not covered. At the time of our review, MCCF staff had not billed insurance carriers for the other eight claims because the COJ had not identified any veterans with reimbursable insurance. However, following our review, MCCF staff agreed to bill an estimated $20,648 for those eight claims.

VA Outpatient Care. We reviewed 15 inpatient discharges occurring on June 15, 2004, and we identified 2 additional billing opportunities totaling $194 for outpatient visits that were related to the inpatient stays. MCCF staff billed for the inpatient stays but missed the related outpatient visits. MCCF staff agreed to issue bills for the visits.

Patients with Unidentified Insurance. The *Patients with Unidentified Insurance Report* for June 2004 listed 68 veterans that did not have insurance providers recorded in the Veterans Health Information Systems and Technology Architecture (VistA) system. We reviewed 10 veterans from the list and found 7 that did have insurance. MCCF staff stated they did not have procedures in place to verify insurance information. They relied on veterans to provide insurance information on their applications for eligibility for VA health care, or they relied on the clinic clerks to ask veterans for updated insurance information. In this case, the procedural vulnerability did not result in loss recovery because the seven veterans that had insurance did not receive care after the effective date of the insurance.

Documentation and Coding of Care Provided. The *Reasons Not Billable Report* from January 1, 2003, to June 30, 2004, listed potential billings for 9,415 episodes of care totaling $1.2 million that were unbilled because of insufficient documentation, no documentation, or non-billable providers (residents). We reviewed 30 potential billings totaling $107,107 and found 25 missed billing opportunities totaling $51,282.

In nine cases totaling $19,533, MCCF staff had not issued bills because medical care providers did not adequately or timely document diagnoses or progress notes. During our review, MCCF staff obtained documentation for three cases and issued bills totaling $16,624. However, they were not able to obtain sufficient documentation for the remaining six cases totaling $2,909. Of these six remaining cases, three had only post operative notes in Computerized Patient Record System, and they were insufficient for coding and billing; two did not have any attending physician documentation; and one had only student notes that were insufficient for billing.

In six cases, MCCF staff could have billed $6,766 for the care provided, but attending physicians did not sufficiently document supervision of residents. VHA policy requires that attending physicians or residents document resident supervision by entering diagnoses or progress notes into the medical records.

In 10 cases, MCCF staff could have billed for the care provided, but coding staff incorrectly assigned a non-billable reason code through an oversight or because the documentation was not present at the time of coding. However, MCCF staff identified adequate documentation for these 10 cases and issued bills totaling $24,983.

Recommended Improvement Action(s) 5. We recommend the VISN Director ensure that the Medical Center Director requires that MCCF staff: (a) strengthen the billing process for fee-basis care by implementing procedures to identify veterans with reimbursable insurance, (b) issue bills for outpatient care related to inpatient care, (c) contact veterans and their employers in order to determine if the veterans have insurance, (d) train physicians to adequately document the care they provided and their supervision of residents, and (e) train coding staff to better recognize whether care is billable.

The VISN and Medical Center Directors concurred with the finding and recommendations. The CRU at Asheville, North Carolina established a workgroup to develop a process to identify fee-basis patients with reimbursable insurance and facilitate billing for fee-basis care. MCCF staff is now billing for encounters with providers on the day of discharge, if appropriate documentation is available when coding the discharge. Staff is now generating telephone calls to veterans to determine if they have insurance and has provided training to intake staff to improve interview techniques related to identifying insurance. Training for medical and coding staff is planned regarding medical record, resident supervision, and billable care documentation. The improvement actions and plans are acceptable, and we will follow up on the planned actions until they are completed.

Unliquidated Obligations - Undelivered Orders and Accrued Services Payable Should Be Thoroughly Reviewed

Condition Needing Improvement. VA policy requires Fiscal Service employees to analyze undelivered orders and accrued services payable reports each month to identify outstanding obligations; it also requires them to contact the requesting services to determine whether the obligations are still needed. For this medical center, these responsibilities were assigned to the Centralized Accounting Unit (CAU) at the VA Medical Center, Salem, Virginia. CAU employees should cancel unneeded obligations and reprogram the funds. CAU employees were not reviewing outstanding undelivered orders and accrued services payable and following up with the requesting services to determine continued need. We identified nine obligations totaling $39,218 that should have been canceled.

Undelivered Orders. As of August 14, 2004, the medical center had 587 undelivered orders totaling $8.7 million. Of these, 42 undelivered orders totaling $338,843 were delinquent (over 90 days old). We reviewed a judgment sample of 16 orders and found that 6 orders totaling $34,791 were no longer needed and should have been canceled.

Accrued Services Payable. As of August 14, 2004, the medical center had 20 accrued services payable totaling $47,049. Of these, four accrued services payable totaling $16,420 were delinquent. Three payables totaling $4,427 were no longer needed and should have been canceled.

Recommended Improvement Action(s) 6. We recommend that the VISN Director ensure that CAU employees at the VA Medical Center Salem, Virginia: (a) analyze unliquidated obligations monthly, (b) follow up with requesting services as to continued need, and (c) cancel the nine unneeded obligations that were identified.

The VISN and Medical Center Directors concurred with the findings and recommendations. The Salem Medical Center Director stated that the Salem CAU has had a process in place since July 2004 to analyze the undelivered orders and accrued services payable each month and to contact the originating staff as to whether the items should remain open or be canceled. The nine unneeded obligations we identified have now been canceled, so we consider that issue resolved. We will follow up to ensure the monthly reviews are thoroughly conducted.

Accounts Receivable - Accounts Receivable Should Be Established Timely and Follow Up on Delinquent Federal Accounts Receivable Needed Improvement

Condition Needing Improvement. We reviewed a judgment sample of 40 accounts receivable valued at $365,161. We found that improvements could be made by establishing accounts receivable timely and aggressively following up on delinquent Federal accounts receivable.

Establishing Accounts Receivable Timely. VHA policy requires that accounts receivable be established 1-day after transactions are completed. Twenty-one receivables were established within 1-day as required; but 19 (valued at $210,327) were not, requiring 6 to 122 days. According to Fiscal Service staff, this occurred because service chiefs were not approving their accounts receivable timely.

Following Up on Delinquent Federal Accounts Receivable. VHA policy requires prompt and aggressive follow up action on accounts receivable. Fiscal Service staff appropriately followed up on 35 of the 40 accounts receivable we reviewed. However, they did not take prompt and aggressive follow up action on five delinquent Federal accounts receivable valued at $236,682. For these accounts, the most recent follow up

activity was April 2003. Fiscal Service staff stated that follow up on delinquent Federal accounts receivable was not done because of insufficient staff.

Recommended Improvement Action(s) 7. We recommended the VISN Director ensure that the Medical Center Director requires medical center staff to: (a) establish accounts receivable timely, and (b) allocate sufficient staff time to aggressively follow up on delinquent Federal accounts receivable.

The VISN and Medical Center Directors concurred with the findings and recommendations. Accounting staff are reviewing all pending receivables on a weekly basis and following up with payroll staff to establish receivables timely. A plan has been developed to allocate supply staff to aggressively follow up on delinquent accounts receivable. Future procedures will include follow up on receivables that are uncollected over 60 days. The improvement actions and plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security - Controls Needed To Be Enhanced

Condition Needing Improvement. We reviewed information technology (IT) security to determine if controls were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Annual security awareness training was provided, password controls were adequate, and critical data were backed up on a regular basis. However, the following areas required management attention.

Storage of Information Resources Management (IRM) Service Back-up Tapes. IRM Service back-up tapes were stored in a secure, remote, and environmentally-controlled location as required by VA policy. However, the back-up tapes were transferred to that location only twice a week. In the interim, they were stored in a closet adjacent to the computer room that did not meet security requirements. The Chief, IRM Service needs to ensure the back-up tapes are always stored in a location that meets requirements for safe and secure storage.

Control of VistA Accounts. The Chief, IRM Service needed to ensure VistA account access is disabled for users that do not access the system for 90 days. We reviewed 16 user accounts that had not been accessed for 90 days as of July 2004, and found 5 that had not been accessed for 90 days but had not been disabled. According to an IRM Service technician, an update to the program was installed in July 2004 that prevented operation of the disabling function. This was corrected during our onsite visit.

Risk Assessments. Local Area Network (LAN), VistA, Gateway, and Private Branch Exchange (PBX) risk assessments were not adequate. Guidelines to prepare a risk assessment are published by the National Institute of Standards and Technology (NIST). We found that the Information Security Officer used the VA Automated Risk Analysis

(ARA) tool for these assessments. However, the ARA tool neither meets NIST requirements nor adequately assesses the threats posed by natural, environmental, or man-made factors. These vulnerabilities and any other additional threats should be documented in a risk assessment plan as mandated by Federal law.

Recommended Improvement Action(s) 8. We recommend that the VISN Director ensure that the Medical Center Director improves IT security by: (a) ensuring that the back-up tapes are always stored in a location that meets requirements for safe and secure storage, (b) ensuring VistA account access is disabled for users that do not access the system for 90 days, and (c) revising the LAN, VistA, Gateway, and PBX risk assessments in accordance with NIST guidelines.

The VISN and Medical Center Directors concurred with the findings and recommendations. Back-up tapes are now stored in a vault at a location that meets requirements for safe and secure storage. VistA account access is now disabled for users that do not access the system for 90 days. The four risk assessments will be revised using new software that is compliant with NIST guidelines. However, since the software for the VistA risk assessment will not be available until May 2005, a NIST-compliant paper risk assessment tool will be conducted to assess the VistA system in the interim. The improvement actions and plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability - Selected Controls Needed Improvement

Condition Needing Improvement. The Chief, Pharmacy Service and the Controlled Substances Coordinator needed to strengthen controls to fully comply with VHA and local policy, and help ensure accountability of controlled substances. The following deficiencies were identified.

72-hour Inventories of Controlled Substances. VHA policy requires a perpetual inventory of all controlled substances that is verified by Pharmacy Service staff at a minimum of every 72 hours. The 72-hour inventory is an important control in identifying discrepancies at an early stage. Our review of the Inpatient/Outpatient Pharmacy Vault found, for the 4-month period ending June 30, 2004, that the documentation to support many of the inventories was missing. We found no documentation for any of the inventories conducted in April 2004. According to the Acting Chief, Pharmacy Service, the controlled substances coordinator borrowed the documentation, never returned it, and subsequently retired. Documentation for the 72-hour inventories was also missing for 2 days in March 2004 and 3 days in May 2004. As a result, we could not determine whether the inventories were conducted. The Acting Chief, Pharmacy Service had no explanation for why these were missing. Additionally, for 2 days in June 2004, a total of 36 controlled substances were not inventoried. According to the Acting Chief, Pharmacy Service, some employees were on leave and substitutes were not assigned.

Reporting Missing Controlled Substances to VA Police. Medical center policy requires that missing controlled substances be reported immediately to the Medical Center Director, who will then report the occurrences to the VA police. We reviewed the seven police investigations regarding missing controlled substances reported from January 1, 2004, through July 31, 2004. On two occasions, missing controlled substances were not reported to VA police until 8 months after the drugs were discovered missing. We could not determine why the occurrences were not reported immediately because the employees involved (including the Medical Center Director) were no longer working at the medical center. According to ward nurses, a controlled substances inspection official told them that the occurrences had not been reported, and the nurses then made the reports to the VA police. VA Police closed both cases because they were not reported timely, and they could not determine why the controlled substances were missing.

Recommended Improvement Action(s) 9. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) all controlled substances inventories are verified at least every 72 hours, and (b) missing controlled substances are reported to the VA police immediately.

The VISN and Medical Center Directors concurred with the findings and recommendations. To ensure compliance with the 72-hour inventory requirements, the medical center adopted several new procedures, including conducting inventories twice a week and establishing controls to verify that the inventories are conducted and the documentation is maintained. All missing controlled substances are now immediately reported to the VA police for investigation. The VA police notify the Pharmacy Service of the missing drugs and report their findings to the Controlled Substances Coordinator. Since the Inpatient/Outpatient Pharmacy Vault is only open five days a week, the twice a week inventories meet the 72-hour requirement. The improvement actions are acceptable, and we consider the issues resolved.

Contract Award and Administration - Strengthen COTR Delegation and Training

Condition Needing Improvement. We reviewed contract administration for three contracts with an estimated value of $7.6 million. Overall, contract administration was adequate for the ambulance and wheelchair van service contracts, but we identified needed improvements for the switchboard operator contract.

VA policy requires that a COTR be assigned in writing to monitor contract performance to ensure that services are provided in accordance with the contract terms. Although an IRM Service employee was the COTR for the switchboard operator contract, there was no documentation officially assigning this employee as the COTR. Also, the employee was not adequately trained to perform the COTR duties. This occurred because the Chief of Staff did not notify the contracting officer, located at the VA Medical Center Hampton, Virginia, that the IRM employee was assigned the COTR duties effective

July 1, 2004. During our review, the Chief of Staff notified the contracting officer who initiated action to designate the IRM employee as the COTR and provide training.

Recommended Improvement Action(s) 10. We recommend that the VISN Director ensure that the Medical Center Director requires that changes to COTR designations are communicated to the contracting officer and new COTRs are provided training.

The VISN and Medical Center Directors concurred with the findings and recommendation. The VISN Centralized Contracting Activity will meet with each COTR at least quarterly and communicate any changes. COTRs will not receive delegations of authority without completing required training. The improvement actions are acceptable, and we consider the issues resolved.

Means Test Certifications - Improvement Was Needed to Ensure Current Means Test Information

Condition Needing Improvement. Eligibility staff needed to ensure means test information was current. Means tests are administered to obtain income information from certain veterans in order to determine whether they are subject to medical co-payments. VHA facilities are required to retain signed means test certification forms in the patients' administrative records. We reviewed administrative records for 30 veterans and found 3 veterans' administrative records did not contain current signed means test certification forms.

The Chief, Health Benefits Section told us that, according to their records, the means test certification forms had been completed and signed when the veterans came in for their latest visits. However, the certification forms could not be located, and the Chief, Health Benefits Section could not explain how this occurred.

Recommended Improvement Action(s) 11. We recommend that the VISN Director ensure that the Medical Center Director: (a) strengthens intake procedures to ensure means test information is current, and (b) obtains current means test certification forms for the three veterans cited in our review.

The VISN and Medical Center Directors concurred with the findings and recommendations. All means test certification forms are now being scanned into the Computerized Patient Record System on a daily basis. A template is being developed to monitor accuracy and ensure all means test certifications are captured. The means test certification forms for the three veterans identified have been signed and scanned into the system. The improvement actions and plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 4, 2004

From: Director, Veterans Integrated Service Network (10N6)

Subject: Hunter Holmes McGuire VA Medical Center Richmond, VA

To: Director, Office of Healthcare Inspections (54 DC)

On behalf of Daniel F. Hoffmann, FACHE, Network Director, VA Mid-Atlantic Health Care Network, VISN 6, the attached follow-up response is forwarded as requested.

Respectfully,

(original signed for Daniel F. Hoffmann, Director VISN 6)

Jill C. Hutchison,
Program Assistant, VISN 6

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 3, 2004

From: Director, Hunter Holmes McGuire VA Medical Center

Subject: Hunter Holmes McGuire VA Medical Center Richmond, VA

To: Network Director (10N6) Attn: Quality Manager, VISN 6, Durham, NC 27701

1. Please refer to Outlook message, dated October 25, 2004, subject as above.

2. Attached, as requested, is the response from the Richmond VA Medical Center for the OIG visit, the week of August 23-27, 2004.

(original signed by:)

MICHAEL B. PHAUP

Attachment

Medical Center 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(s) 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) patient and staff areas are clean, (b) patient information is secured, and (c) prescription pads are secured.

Concur

The following actions have been initiated:

a. During the month of September, all Environmental Management Section (EMS) employees were retrained on the appropriate methods and procedures to use when cleaning bathrooms and restrooms in their assigned areas. EMS supervisors were required to prepare and implement project schedules to scrub and detail bathrooms and restrooms throughout the facility. This project has been completed. EMS supervisors have been instructed to place greater emphasis on these areas during their documented inspections.

Responsibility: Chief, Facility Management

Target Date: Oct. 29, 2004

Refrigerators located in nourishment kitchens throughout the medical center are scheduled for weekly cleaning and inspection to include the removal of outdated items.

Responsibility: Chief, Facility Management

Target Date: Oct. 29, 2004

Refresher training on required procedures for terminal/discharge cleaning of patient rooms for EMS employees is scheduled for November 2004. Supervisors will increase the frequency of inspections of rooms that have been prepared to receive new patients, to insure compliance with required procedures.

Responsibility: Chief, Facility Management

Target Date: Nov. 30, 2004

EMS provided an initial cleaning of accessible microwaves throughout the medical center in September 2004. Recurring maintenance of the units is the responsibility of the users. EMS supervisors will routinely inspect microwaves biweekly and notify individual users when sanitation deficiencies are noted. It is the responsibility of each individual area to clean their microwave.

Responsibility: Chief, Facility Management, Nurse Manager

Target Date: Oct. 29, 2004

b. Patient Confidentiality. Richmond VAMC is committed to safeguarding the confidentiality and integrity of sensitive patient data. All employees are required to sign a Rules of Behavior statement adhering to patient confidentiality and computer system regulations. The facility Information Security Officer (ISO) ensures that cyber security refresher training is accomplished and will also target the aforementioned areas with an emphasis on computer log off procedures. The facility ISO and the HIPAA Compliance Officer will conduct frequent physical inspections for compliance with patient confidentiality documentation and computer security breaches. Management will ensure that service chiefs and supervisors make employees aware and accountable and require that best practices for patient confidentiality be applied at all times.

Responsibility: Information Security Officer

Target Date: Dec. 31, 2004

c. Pharmacy Service is responsible for storing and issuing of the prescription pads (form 10-2577F). Pharmacy Service monitors records of all personnel who have been issued these forms. Once issued, it is the responsibility of the clinical service receiving these forms to maintain the security of the forms. Supervisors in clinical areas will ensure the security of the forms. The Police will be contacted if there is suspicion of stolen forms. They will be monitored by key staff on weekly EOC rounds and any deviation will be reported to the Associate Director and/or Chief of Staff.

Responsibility: Chief, Pharmacy Service, Associate Director, Service Chiefs

Target Date: October 29, 2004

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensure that the Medical Center Director requires that the Contracting Officer Technical Representative (COTR) properly document modifications to the bulk oxygen utility system contract in a mutual agreement and send a copy to the National Acquisition Center (NAC).

Concur

The following actions have been initiated:

On August 3, 2004, Materiel Management Service communicated with the NAC and requested that current contract be amended to restrict deliveries to Monday through Friday, 8:00 am to 3:30 pm. Also at the time of delivery, it has been requested that the driver be required to contact the Supply, Processing and Distribution Section to ensure a VA employee monitors each delivery.

Responsibility: Chief, Materiel Management Service

Target Date: January 1, 2005

Recommended Improvement Action(s) 3. The VISN Director needs to ensure that the Medical Center Director requires that: (a) pre-sedation assessments are co-signed by a physician timely, (b) clinicians complete required moderate

sedation training, and (c) managers report all moderate sedation outcomes to the Chief, Anesthesiology Service.

Concur

The following actions have been initiated:

a. The pre-sedation assessment form is being altered; therefore the patient record will reflect an immediate pre-procedure reassessment by the physician. The form will also separate the original history and physical from this pre-procedure reassessment.

Responsibility: Chief, Anesthesiology

Target Date: Nov. 30, 2004

b. The new policy will define the educational requirements of those who supervise conscious sedation (an attending physician) and those who administer conscious sedation (nurses and/or residents). Supervising physicians who are applying for new privileges or who have not supervised more than five conscious sedation cases in the previous two years must complete the education packet. Those physicians who have successfully supervised five or more conscious sedation cases, with an acceptable complication rate, need not complete the packet. All those who administer conscious sedation, under the direct supervision of an appropriately privileged attending physician, must complete the education packet. The education packet will be provided through Education Service Line who will document a record of completion.

Responsibility: Chief, Anesthesiology, Education Service Line

Target Date: Dec. 31, 2004

c. The new Conscious Sedation policy will delineate QA reporting pathways. These pathways are designed to achieve maximum conscious sedation QA capture and reporting using pre-existing policies and administrative structures. Individual services must report QA data related to conscious sedation directly to the Chief, Anesthesiology Service who will report

to the Quality Assessment Improvement Committee (QAIC). All incident reports received by the Risk Manager related to conscious sedation will be forwarded to the Chief, Anesthesiology Service for review.

Responsibility: Chief, Anesthesiology, Risk Manager

Target Date: Dec. 31, 2004

Recommended Improvement Action(s) 4. We recommend that the VISN Director ensure that the Medical Center Director obtain the scanning equipment needed to effectively manage supplies and reduce supply stock levels to meet the 30-day goal.

Concur

The following actions have been initiated:

a. At the time of the OIG visit, the judgment sample of supply inventory was valued at $66,355, and 56 percent of this total exceeded 30 days. Currently the same sample represents $18,096 of inventory value, and 42 percent of this total exceeds 30 days, indicating a 25% improvement.

Six inventory scanners and 4 barcode printers were received from the VISN on August 30, 2004, and have been installed. VISN sponsored training was completed on October 18, 2004 and October 26, 2004. The need for additional resources will continue to be evaluated and will be requested as appropriate.

Responsibility: Chief, Materiel Management

Target Date: October 29, 2004.

Recommended Improvement Action(s) 5. We recommend the VISN Director ensure that the Medical Center Director require that MCCF staff: (a) strengthen the billing process for fee-basis care by implementing procedures to identify veterans with reimbursable insurance, (b) issue bills for outpatient care related to inpatient care, (c) contact veterans and their employers in order to determine if the veterans have insurance, and (d) train physicians to adequately document the care they provided and their supervision of residents, and

train coding staff to make correct decisions as to whether or not care is billable.

Concur

The following actions have been initiated:

a. The Consolidated Revenue Unit, Asheville, NC has established a workgroup to develop a process to identify fee basis patients with reimbursable insurance and facilitate billing for VISN 6 Medical Centers.

Responsibility: Chief, Fiscal Service

Target Date: March 1, 2005

b. Billing is occurring for encounters with providers on the day of discharge, if appropriate documentation is available when coding the discharge.

Responsibility: Chief, Fiscal Service

Target Date: October 29, 2004

c. During the IG visit, the investigator generated a report from the Diagnostic Measures Report files of Patients Not Covered by Insurance. This report can be generated to reflect veterans who do not have insurance but do have a work telephone number listed. In order to determine if the veteran has insurance, a telephone call must be generated to the telephone number listed on the report to ascertain if the veteran has insurance. If the veteran has insurance, the information is then loaded into the Insurance Buffer file. If the veteran does not have insurance, the caller must answer "no" to the insurance prompt on the insurance screen. Staff will review this list on an annual basis. In addition, we plan on improving the interview techniques of the Intake staff by providing them with additional training. This will be completed by November 30, 2004. Since the IG CAP visit, we are reviewing the Unidentified Insurance report on a daily basis. In the event that the insurance prompt was not answered on the previous days encounter, we are contacting the patients/employers to populate this field.

Responsibility: Chief, HAS

Target Date: November 30, 2004

c. 1) The Associate Chief of Staff for Education will assist the facility Compliance Officer in arranging training on accurate medical record documentation for medical staff.

Responsibility: ACOS/Education, Compliance Officer

Target Date: Dec. 1, 2004

2) The Associate Chief of Staff for Education will disseminate information and provide refresher training to supervising practitioners concerning the new VHA Resident Supervision Handbook 1400.1 (May 2004). A workgroup is being developed to analyze if a Net-Six education module would benefit the medical center.

Responsibility: ACOS/Education

Target Date: Dec. 1, 2004

3) The Associate Chief of Staff for Education, in conjunction with Chief, Health Administration Service, will arrange for training for the coding staff, to assist them in making correct decisions as to whether or not care is billable.

Responsibility: ACOS/Education, Chief, HAS

Target Date: April 1, 2005

Recommended Improvement Action(s) 6. We recommend that the VISN Director ensure that Centralized Accounting Unit (CAU) employees at the VA Medical Center Salem, Virginia: (a) analyze unliquidated obligations monthly, (b) follow up with requesting services as to continued need, and (c) cancel the nine unneeded obligations that were identified.

Concur

a. The Salem CAU staff currently reviews undelivered order listings for each medical center. I believe that our proactive

stance was recognized with the number one rank in the performance measure financial indicators for August. This process has been in place since the beginning of July 2004, following a meeting with the VISN Chief Logistics Officer (CLO) and Deputy Network Director (DND).

b. Salem currently has the following process in place and this has been in place since the beginning of July 2004 following a meeting with the VISN CLO and DND. At the end of each month the CAU staff reviews the accounts payable and accrued services payable listings. During the review, the Medical Center staff (Control Point Officials, purchasing agents, contracting officers, etc.) are contacted concerning the outstanding item. If one of these individuals indicates and justifies that the order should remain open, the staff notates the report and leaves the item open pending review the following month. The CAU director has requested that the VISN CLO insure that the procurement menus be modified so that the procurement official could modify the order. If, due to unforeseen circumstances, the delivery date needs to be extended. (Currently this option exists only in Salem and Salisbury.)

c. The CAU director requested that staff pull the records for Richmond for the end of September. The nine unneeded obligations identified in your review have been cancelled.

Responsibility: Chief, Fiscal

Target Date: October 29, 2004

Recommended Improvement Action(s) 7. We recommend the VISN Director ensure that the Medical Center Director require medical center staff to: (a) establish accounts receivable timely, and (b) allocate sufficient staff time to aggressively follow up on delinquent Federal accounts receivable.

Concur

The following actions have been initiated:

a. Most of the problem receivables were employee receivables and originated in the Payroll Section of Fiscal Service. Accounting staff are reviewing all receivables pending approval on a weekly basis, and follow up with Payroll is completed on any outstanding receivables. Receivables will be established within a week of follow up. The Payroll supervisor will review each receivable before releasing.

b. Responsibility for follow up on federal accounts receivable has been assigned to the Accounting section. A plan has been developed to allocate supply staff to aggressively follow up in delinquent accounts receivable. Accounting is monitoring the aged receivables until they are resolved. Most of them are the Department of Air Force receivables and contacts and procedures have not been established. Future procedures will include follow up on the receivables once they are over 60 days old and remain uncollected.

Responsibility: Chief, Fiscal Service

Target Date: October 29, 2004

Recommended Improvement Action(s) 8. We recommend that the VISN Director ensure that the Medical Center Director improve IT security by: (a) ensuring that the back-up tapes are always stored in a location that meet requirements for safe and secure storage, (b) ensuring VistA account access is disabled for users that do not access the system for 90 days, and (c) revising the LAN, VistA, Gateway, and PBX risk assessments in accordance with NIST guidelines.

Concur

The following actions have been initiated:

a. Back-up tapes are now stored in a location that meet requirements for safe and secure storage. Backup tapes are transported daily to the vault in Building 507. This is accomplished by the VistA team on-call person.

Responsibility: ACOS/Information Technology

Target Date: Oct. 29, 2004

b. VistA account access is disabled for users that do not access the system for 90 days via the option Purge Inactive User Attributes. At the time of the audit, we were testing a VA Kernel patch that caused the option to malfunction. This deficiency was resolved with a software patch to the VA Kernel (XU*8.0*360).

Responsibility: ACOS/Information Technology

Target Date: Oct. 29, 2004

c. Risk assessments for Local Area Network (LAN), Gateway and Private Branch Exchange (PBX) will be revised using a new Risk Watch software that is compliant with National Institute of Standards Technology (NIST) guidelines. This endeavor is included in the contract awarded to Delta Security Technologies (DST) for the Richmond certification and accreditation (C&A) of the aforementioned systems. DST anticipates completion in approximately four to six months.

The Office of Cyber and Information Security (OCIS) will be deploying NIST compliant Risk Watch software for conducting the VistA risk assessment. However, this tool will not be available until May 2005. Therefore, a NIST compliant paper risk assessment tool will be conducted to assess the VistA system in the interim.

Responsibility: ACOS/Information Technology

Target Date: April 30, 2005

Recommended Improvement Action(s) 9. We recommend that the VISN Director ensure that the Medical Center Director require that: (a) all controlled substances inventories are verified at least every 72 hours, and (b) missing controlled substances are reported to the VA police immediately.

Concur

The following actions have been initiated:

a. Reporting Missing Controlled Substances: All missing controlled substances are reported immediately to the Police for investigation. This issue was reinforced with staff and has been working well. The inspectors give the nurse manager a copy of the discrepancies at the conclusion of the inspection. Nurse managers report all missing drugs to the Police immediately upon receiving notification. Police Service notifies Pharmacy Service to make them aware of the missing drugs. Police Service report their findings from the investigations to the Controlled Substance Coordinator (CSC). When drugs cannot be tracked, a report is submitted to DEA.

Responsibility: Chief Of Staff, Chief of Police

Target Date: October 29, 2004

b. 72 Hour Inventory: To ensure compliance with the 72 hour inventory of controlled substances as mandated by VHA policy, the inpatient/outpatient narcotic vault adopted the following procedures:

(1) Inventories are conducted at times prescribed by VHA policy.

(2) Specific areas are assigned to the staff members and alternates are assigned to each area. Staff was educated to inform the narcotic supervisor if an inventory is missed or cannot be completed.

(3) Staff initial a daily calendar after completing an inventory.

(4) If for any reason (holiday) an inventory is not conducted, an inventory will be completed on the next business day. This is noted on the inventory and on the calendar.

(5) The narcotic supervisor checks each week to ensure that all inventories have been completed and will report any problems and/or any incomplete or missed inventories to the Chief, Pharmacy Service.

(6) Original inventories are no longer given to inspectors during monthly inspections. Inspectors are given copies.

(7) During monthly inspections, each inventory will be signed by both an inspector and a pharmacy staff member.

(8) After each monthly inspection the inventories will be filed.

Responsibility: Chief Of Staff, Chief of Police

Target Date: October 29, 2004

Recommended Improvement Action(s) 10. We recommend that the VISN Director ensure that the Medical Center Director require that changes to COTR designations are communicated to the contracting officer and new COTRs are provided training.

Concur

The following actions have been initiated:

The VISN Centralized Contracting Activity meets with each COTR at least quarterly, at which time changes would be communicated. COTRs do not receive delegations of authority without completing required training.

Responsibility: Chief, Materiel Management

Target Date: October 29, 2004

Recommended Improvement Action(s) 11. We recommend that the VISN Director ensure that the Medical Center Director: (a) strengthens intake procedures to ensure means test information is current, and (b) obtains current means test certification forms for the three veterans cited in our review.

Concur

a. All financial applications (means tests) are currently being scanned into the Computerized Patient Record System (CPRS) on a daily basis. To ensure compliance, a Fileman Print Template is being developed to monitor the accuracy of all scanned means test documents and to ensure that all signed means test documents are captured in CPRS.

Responsibility: Chief, HAS

Target Date: November 15, 2004

b. The means test applications for the veterans identified have been signed by the respective veterans and scanned into CPRS, as well as placed in the veteran's administrative record.

Responsibility: Chief, HAS

Target Date: October 29, 2004

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
4	Reducing supply inventories to 30-day levels.	$860,000
5	Enhancing MCCF billing and collections.	20,195
6	Canceling unneeded obligations.	39,218
	Total	$919,413

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director, Washington, DC Regional Office of Healthcare Inspections (202) 565-8181
Acknowledgments	Randall G. Snow, Healthcare Team Leader Robert C. Zabel, Audit Team Leader Sarah Lake, Investigations Team Leader James L. Garrison C. Russell Lewis Ken Myers Rayda Nadal Michelle D. Porter Jason D. Schuenemann Oscar L. Williams

Appendix E

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