Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas

Report No. 04-02293-73 **January 28, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of July 12-16, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the West Texas VA Health Care System (the System). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 150 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

The CAP review covered 11 areas. The System complied with selected standards in the following four areas:

- Environment of Care
- Equipment Accountability
- Moderate Sedation
- Quality Management

Based on our review, the following organizational strength was identified:

- Equipment accountability was effective.

To improve operations, the following seven recommendations were made:

- Strengthen supply inventory management.
- Increase Medical Care Collections Fund (MCCF) collections by improving documentation and billing procedures.
- Improve information technology (IT) security by adding information to the contingency plan and disabling inactive accounts.
- Perform controlled substances inventories and maintain accountability over the disposition of unusable controlled substances.
- Improve compliance with certain contracting requirements.
- Comply with bulk oxygen contract requirements and ensure that the bulk oxygen system has a minimum of two alarm panels that operate independently.
- Ensure purchase cardholders' purchase limits do not exceed their warrant authorities.

This report was prepared under the direction of Mr. Michael Guier, Director, Dallas Audit Operations Division and Mr. Jehri Lawson, CAP Review Coordinator, Dallas Audit Operations Division.

VISN 18 and System Director Comments

The VISN 18 Director and the System Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 13-24 for the full text of the Directors' comments.) We will follow up on planned improvement actions until they are completed.

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

Introduction

System Profile

Organization. The System provides inpatient and outpatient health care services in Big Spring, Texas. Outpatient care is also provided at six community-based outpatient clinics located in Abilene, Fort Stockton, Odessa, San Angelo, and Stamford, Texas, and Hobbs, New Mexico. The System is part of VISN 18 and serves a veteran population of about 62,000 residing in 47 counties in west Texas and New Mexico.

Programs. The System provides primary care, medical, surgical, and psychiatric services. It also offers rehabilitation, substance abuse, and dental services. As of May 31, 2004, the System had a total of 65 operating beds, including 25 acute care and 40 nursing home care beds.

Affiliations and Research. The System is affiliated with the Texas Tech University Health Science Center and supports three resident positions. It also has affiliations with eight other institutions providing clinical training opportunities in nursing, physical therapy, ophthalmology, dental hygiene, and radiology. The System does not have a research program.

Resources. In Fiscal Year (FY) 2003, the System's medical care expenditures totaled $59 million. The FY 2004 medical care budget was $63 million. In FY 2004, the System had 493 full-time equivalent employees (FTE), which included 29 physician FTE and 128 nursing FTE.

Workload. The System treated 16,329 unique patients in FY 2003. Inpatient workload totaled 1,124 discharges in FY 2003 and 635 discharges in FY 2004 (through May 31, 2004). The average daily patient census in FY 2004 (through May 31, 2004) was 13 for acute care and 34 for nursing home care. The outpatient workload totaled 115,231 visits for FY 2003 and 86,287 visits in FY 2004 (through May 31, 2004).

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, QM, 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. The review covered facility operations for FY 2003 and FY 2004 through May 2004, and it 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:

- Bulk Oxygen Utility System
- Controlled Substances
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Medical Care Collections Fund
- Moderate Sedation
- Quality Management
- Service Contracts
- Supply Inventory Management

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all System employees, and 81 responded. We also interviewed 27 patients during the review. The survey results were shared with System managers.

We also presented four fraud and integrity awareness training sessions for System employees. A total of 150 employees attended the training, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Organizational Strength or Opportunities for Improvement sections, there were no reportable conditions.

Results of Review

Organizational Strength

Equipment Accountability Was Effective. System managers maintained proper equipment accountability. We inventoried a judgment sample of 26 equipment items valued at about $340,000 and compared the inventory results to items recorded on Equipment Inventory Listings (EILs) to determine whether managers properly accounted for their equipment. We also traced seven equipment items that we observed in various areas back to the appropriate EILs to ensure that each item was listed on an EIL. Our review showed that all 33 equipment items were properly accounted for and recorded on EILs.

Opportunities for Improvement

Supply Inventory Management – Inventory Controls Should Be Strengthened and Stock Levels Should Be Reduced

Condition Needing Improvement. The System needed to maintain accurate inventory records and reduce stock levels of supplies.

Veterans Health Administration (VHA) policy requires that medical facilities use the automated Generic Inventory Package (GIP) to manage inventories and establishes a 30-day supply goal. At the time of our review, GIP data showed the System's supply inventory included 62 line items in the warehouse primary inventory point valued at $10,286; 190 line items in the combined Environmental Management Service and Engineering Service (EMS/ENG) primary inventory point valued at $27,590; and 1,096 line items in the Supply Processing and Distribution (SPD) activity primary inventory point valued at $82,263.

We analyzed GIP data for all line items in the warehouse, EMS/ENG, and SPD primary inventory points. In addition, we inventoried quantities on hand and reviewed usage rates for a judgment sample of 35 line items to assess the accuracy of inventory records and the appropriateness of the normal stock levels[1] established by inventory managers. The 35 line items in our sample had a combined value of $14,438.

Inaccurate Inventory Records. To assess the accuracy of GIP data, we inventoried 4 line items stored in the warehouse, 8 line items stored in the EMS/ENG primary inventory point, and 23 line items stored in the SPD activity. The quantities recorded in GIP were accurate for the warehouse items. Except for one overage valued at $8, the recorded quantities for the eight EMS/ENG line items were also accurate. However, the quantities

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

recorded in GIP for 10 of the 23 line items in the SPD activity were inaccurate, with 2 overages valued at $184 and 8 shortages valued at $2,479. The inaccurate GIP inventory records occurred because System personnel did not record receipts accurately and post distributions promptly. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. GIP data indicated that stock levels on hand and normal stock levels were higher than needed. The stock levels of 1,238 of the 1,348 (92 percent) line items stored in the 3 primary inventory points exceeded the 30-day level. The total recorded value of supplies in excess of the 30-day level was about $44,460. In addition, our analysis of the normal stock levels established for the 35 line items in our judgment sample showed that the normal stock levels needed to be reduced for 9 of the items. The normal stock levels for the nine line items represented 36 to 600 days of stock. Reducing stock levels would lower holding costs and make more funds available for other uses.

Recommended Improvement Action 1. We recommended the VISN Director ensure the System Director takes action to: (a) reconcile differences and correct inventory records as appropriate; (b) provide refresher training for SPD personnel, emphasizing the importance of recording receipts accurately and posting distributions promptly; and (c) reduce stock levels to adhere to the 30-day goal.

The VISN and System Directors agreed with the finding and recommendations and reported that a comprehensive inventory has been completed in the EMS/ENG primary inventory point and all of the inventoried quantities were entered into GIP. The System will complete comprehensive inventories of the warehouse and SPD by January 31, 2005. SPD personnel have received training on recording receipts and posting distributions. When conducting comprehensive inventories, System personnel are taking actions to assist in achieving the 30-day goal, such as turning in unneeded items or returning items to vendors for credit. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Collections from Insurance Carriers Could Be Increased

Condition Needing Improvement. The System could increase MCCF collections by obtaining insurance information from veterans at the time of treatment, improving documentation of medical care, ensuring MCCF personnel identify all billable care, and submitting documentation of fee-basis care promptly to MCCF personnel.

Under the MCCF program, VA is authorized to recover from insurance carriers the cost of treating insured veterans. In FY 2003, the System collected $4,606,209, which was 82 percent of its FY 2003 collection goal of $5,642,716. In the first 8 months of FY 2004, the System collected $2,831,552, which was 53 percent of its FY 2004 collection goal of $5,350,000.

Insurance Information. System managers needed to ensure that eligibility and clinic clerks obtain insurance information from veterans at the time of treatment so that MCCF personnel could bill insurance carriers promptly. We reviewed the records of a judgment sample of 10 veterans from the "Detailed Patients with Unidentified Insurance Report" for April 2004. We found that System personnel had not obtained insurance information for the 10 veterans even though the veterans had been treated 2 to 54 months prior to our review. During our review, MCCF personnel obtained insurance information for 6 of the 10 veterans and sent letters requesting insurance information to the remaining 4 veterans.

We analyzed a judgment sample of 12 outpatient visits from the "Unbilled Amounts Detail Report" for the period October 1, 2003, to May 31, 2004, and identified similar delays in obtaining insurance information. Although MCCF personnel billed all 12 visits prior to our review, billing delays occurred because System personnel had not obtained insurance information until 163 to 219 days after the dates of treatment. Since insurance carriers impose time limits for submitting claims, delays in obtaining insurance information may result in denied claims.

Documentation of Care Provided. The "Reasons Not Billable Report" for the period December 1, 2003, through May 31, 2004, listed 103 potentially billable cases totaling $6,950 that MCCF personnel did not bill because medical care providers did not adequately document care provided in veterans' medical records. We reviewed a judgment sample of 30 of the potentially billable cases and found that 26 cases totaling $2,169 could have been billed if medical documentation had been complete. For 19 of the 26 cases, MCCF personnel did not issue bills because medical care providers did not adequately document diagnosis information in the veterans' medical records. In the remaining seven cases, medical care providers did not adequately document the continuing need for the care provided. Complete documentation of care would result in increased MCCF billings and collections.

Identification of Billable VA Care. We reviewed the records of a judgment sample of 15 inpatient discharges during the period February 29 to March 31, 2004, and found that MCCF personnel appropriately billed for the medical care provided to 14 of the 15 veterans. However, we identified a missed billing opportunity for one veteran valued at $197. After we informed MCCF personnel of the missed billing opportunity, they promptly submitted a claim to the insurance carrier.

Identification of Billable Fee-Basis Care. From October 1, 2003, through April 30, 2004, the System's Fee-Basis Unit paid 861 claims totaling $234,928 to non-VA providers who delivered medical care to veterans with insurance. To determine whether fee-basis care was billed to veterans' insurance carriers, we reviewed a judgment sample of 15 claims. Six of the claims were not billable to the insurance carriers, either because the fee-basis care was for service-connected conditions, for which VA is the primary payer, or because the claims were not billable under the terms of the insurance plans. From the remaining nine claims, we found one missed billing opportunity totaling $40,445. When we

brought the missed billing opportunity to the attention of MCCF personnel, they promptly submitted a claim to the insurance carrier.

Timeliness of Billings for Fee-Basis Care. After authorizing payments to non-VA providers who furnished medical care to veterans with insurance, the Fee-Basis Unit is required to forward to MCCF personnel the documentation needed for billing the veterans' insurance carriers. However, the Fee-Basis Unit did not forward this documentation promptly to MCCF personnel. As a result, the MCCF billings we reviewed were delayed by as much as 182 days after the claims were authorized. The System could increase its MCCF collections by requiring the Fee-Basis Unit to forward the documentation required for billing insurance carriers promptly to MCCF personnel.

Potential Collections. Obtaining insurance information promptly, ensuring medical care providers adequately document care provided in medical records, and identifying all billable care will enhance MCCF collections. We estimated that additional bills totaling $42,811 ($2,169 + $197 + $40,445) could have been issued. Based on the System's historical collection rate of 35 percent, MCCF personnel could have increased collections by $14,983 ($42,811 x 35 percent).

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director requires that: (a) eligibility and clinic clerks obtain insurance information at the time of treatment, (b) medical care providers adequately document the care provided in veterans' medical records, (c) MCCF personnel identify and bill all billable VA and fee-basis care, and (d) the Fee-Basis Unit forwards the documentation required for billing insurance carriers promptly to MCCF personnel.

The VISN and System Directors agreed with the finding and recommendations and reported several improvements to the MCCF program. Refresher training has been provided to patient registration personnel. Program controls have been established to monitor insurance verification procedures, and a new pre-registration software program that will require clinic clerks to update insurance information upon patient check-in was to be implemented by December 31, 2004. System managers have established procedures to identify and train medical care providers who fail to adequately document the care provided in veterans' medical records and to ensure all billable VA and fee-basis care is billed. In addition, monthly audits have been implemented to identify coding discrepancies. The Fee-Basis Unit is now forwarding the documentation required for billing insurance carriers to MCCF personnel daily. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – The Contingency Plan Needed Additional Information and Inactive Accounts Needed To Be Disabled

Condition Needing Improvement. VHA policy requires that physical devices and control measures be used to protect IT assets and sensitive information from misuse and damage in the event of accidents, fires, power outages, environmental hazards, or malicious acts. We evaluated IT security and concluded that controls were generally adequate. Recently hired employees received computer security awareness training, and experienced employees received annual refresher training. Alternative 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. However, we identified two issues requiring management attention.

Contingency Plan. The System's contingency plan could be improved. A contingency plan addresses the procedures for responding to emergencies, backing up data files and storing backup tapes offsite, ensuring that essential business functions can be conducted after disruption of IT support, and restoring facility processing capability. In addition, a contingency plan identifies all equipment needed to support critical system functions in the event of a disaster. Although the System's contingency plan outlined disaster recovery procedures, it did not include a comprehensive list of IT equipment needed to support critical IT system functions. This list is essential because it facilitates continuity of operations and helps prevent major disruptions in patient care during an unexpected system failure.

System Access. The Information Security Officer (ISO) did not ensure that IT system access privileges were reviewed and, when necessary, disabled in a timely manner. VHA policy requires ISOs to review user access at least every 90 days to ensure that levels of access are appropriate and that continued access is needed. VHA policy also requires System personnel to disable accounts that have been inactive for 90 days. We identified 13 active Veterans Health Information Systems and Technology Architecture (VistA) accounts that should have been disabled because they had not been accessed in 90 days or more. Ten of the accounts, which dated as far back as 1994, had not been accessed since they were created. The remaining three accounts had not been accessed since 2001.

Recommended Improvement Action 3. We recommended the VISN Director ensure that the System Director takes action to: (a) add a list of critical IT equipment to the contingency plan, and (b) review user access at least every 90 days and promptly disable accounts that have not been accessed in 90 days or more.

The VISN and System Directors agreed with the finding and recommendations and reported that the contingency plan was updated with a list of critical IT equipment during the CAP review. In addition, procedures are in place to ensure that user access is reviewed every 30 days and that users are deactivated after 90 days of inactivity. The

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

Controlled Substances – Accountability Needed To Be Strengthened

Condition Needing Improvement. System managers needed to strengthen controlled substances accountability. We reviewed pharmacy policies and records to determine if controls were adequate to prevent the loss or diversion of controlled substances and to ensure that Pharmacy Service personnel properly accounted for controlled substances. We also observed unannounced monthly inspections and interviewed Pharmacy Service personnel. Our review showed that controls over controlled substances were generally effective. Physical security was adequate, and the number of employees accessing the storage vault was within permitted limits. In addition, controlled substances inspection procedures were effective, and inspectors were properly trained. However, System managers needed to ensure that Pharmacy Service personnel complete inventories in accordance with VHA policy and maintain accountability for unusable controlled substances.

Required Inventories. VHA policy requires Pharmacy Service personnel to maintain a perpetual inventory of controlled substances and to reconcile inventory records to actual stock on hand at intervals of no more than 72 hours. Pharmacies open 5 days per week must complete two inventory checks each week, while pharmacies open 6 or 7 days per week must complete three inventory checks each week. We reviewed the controlled substances inspection reports for the period January through May 2004 and found that Pharmacy Service personnel did not perform 7 of 42 required 72-hour inventories. On three additional occasions, 72-hour inventories were only partially completed because Pharmacy Service personnel did not inventory Schedule IV and Schedule V controlled substances.

Disposition of Controlled Substances. Pharmacy Service personnel did not maintain adequate accountability over unusable controlled substances. Pharmacy Service personnel are required to destroy or turn in unusable controlled substances to a Drug Enforcement Administration-approved company for disposition on a quarterly basis. Accountability must be maintained until the controlled substances are destroyed or turned in to the company and validated by a returned receipt.

During our observation of an unannounced monthly inspection, the inspector could not find six unusable controlled substances listed on the Pharmacy Service's "Destruction Holding Report." In contrast, the inspector found one other unusable controlled substance in the destruction holding bin that was listed on the "Registrants Inventory of Drugs Surrendered Report," which indicated it had already been destroyed or returned.

Recommended Improvement Action 4. We recommended the VISN Director ensure the System Director takes action to: (a) ensure Pharmacy Service personnel

complete all 72-hour inventories, and (b) emphasize the importance of maintaining accountability over the disposition of unusable controlled substances.

The VISN and System Directors agreed with the finding and recommendations and reported that inspectors are verifying that the 72-hour inventories have been completed. Missed inventories will be reported to the Director. The System has established procedures to ensure that Pharmacy Service personnel maintain accountability over the disposition of unusable controlled substances. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts – Contracting Activities Needed Improvement

Condition Needing Improvement. To evaluate System contracting activities, we reviewed a judgment sample of 14 service contracts valued at about $1.9 million. Contracting officers (COs) used noncompetitive acquisition procedures for nine of the contracts and competitive bidding procedures for five contracts. Our review showed that COs had appropriate warrant authorities, contract files were generally well organized, billing and payment procedures were adequate, and community nursing homes (CNHs) were evaluated prior to issuance of contracts, as well as on an annual basis. However, we identified four issues requiring management attention.

Guidance Concerning Conflicts of Interest. VHA policy requires that all physician supervisors or managers receive copies of VHA Handbook 1660.3, which provides guidance for avoiding conflicts of interest, and acknowledge receipt in writing to indicate they understand and agree to abide by the guidance. We reviewed the Official Personnel Folders of five supervisors or managers and found that one had not signed the required acknowledgment.

Follow-Up on Community Nursing Home Evaluations. VHA policy requires that CNH review teams evaluate CNHs prior to awarding contracts, as well as on an annual basis. In addition, the CNH review teams should follow up on deficiencies discovered during the evaluations. We reviewed 5 CNH contract files and found that CNH review teams did not follow up on deficiencies reported by the safety officer in 6 of 14 initial or annual evaluations.

Contracting Officers' Technical Representative Training. VHA policy requires that COs ensure designated contracting officers' technical representatives (COTRs) receive COTR training. Our review of the training records for six COTRs showed that none had received the required training.

Contract Documentation. Federal Acquisition Regulations require that COs ensure contract files contain all relevant contract documentation. Although the contract files we reviewed generally included appropriate documentation, 7 of the 14 files did not contain all of the required documents. For example:

- The files for four competitive contracts did not include solicitation documents, evidence of bids, or written designations of the COTRs.
- The files for two noncompetitive contracts did not contain justifications for using noncompetitive acquisition procedures.
- The files for one noncompetitive contract did not include a price negotiation memorandum.

Recommended Improvement Action 5. We recommended the VISN Director ensure that the System Director takes action to: (a) provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt, (b) ensure that the CNH review team follows up on deficiencies identified, (c) ensure that each COTR has received required training, and (d) include all required documentation in contract files.

The VISN and System Directors agreed with the finding and recommendations and reported that appropriate staff members were given a copy of VHA Handbook 1660.3 and signed the prescribed acknowledgment form. All identified CNH deficiencies have been corrected, and copies of the corrective actions taken were placed in the appropriate contract files. The CNH Oversight Committee now tracks CNH inspections until all issues are resolved. All of the System's COTRs have received the required training and will receive refresher training on an annual basis. A tracking system has been established to monitor COTR training. Contracting personnel have received training regarding contract documentation requirements, and random contract file reviews are being performed monthly to ensure compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Bulk Oxygen Utility System – Controls Needed To Be Strengthened

Condition Needing Improvement. System managers needed to establish a memorandum of understanding (MOU) with the local bulk oxygen vendor and ensure that the bulk oxygen utility system has a minimum of two alarm panels that operate independently.

Memorandum of Understanding. We reviewed the bulk oxygen contract, which was dated December 12, 1999, and found that the System had not established an MOU with the local bulk oxygen vendor. The MOU is needed to specify both the System's and the vendor's contract responsibilities and to describe the services the vendor will provide. The VA National Acquisition Center requires that an MOU be established between a facility and a local bulk oxygen vendor within 15 days of awarding the contract to the vendor.

Alarm Panels. Alarm panels located at the System's two bulk oxygen utility system monitoring stations were not designed to operate independently. Consequently, if one

alarm panel malfunctioned, the second one could also malfunction. This would leave the System without an effective means to monitor the bulk oxygen utility system. The VHA Patient Safety Alert issued April 5, 2004, requires that medical facilities have a minimum of two alarm panels that operate independently.

Recommended Improvement Action 6. We recommended the VISN Director ensure that the System Director: (a) establishes an MOU with the local bulk oxygen vendor, and (b) requires that the bulk oxygen utility system have a minimum of two alarm panels that operate independently.

The VISN and System Directors agreed with the finding and recommendations and reported that an MOU has been established. In addition, the System will have a minimum of two alarm panels operating independently by July 15, 2005. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Improvements Were Needed to Ensure Purchases Were Within Warrant Authority Limits

Condition Needing Improvement. In general, the System had established effective controls to ensure that purchases were appropriate and were meeting the financial and administrative requirements of the Government Purchase Card Program. Cardholder, approving official, and coordinator responsibilities were properly separated, and purchase card reconciliations were performed timely. In addition, we found no evidence of unauthorized purchases. However, the System needed to ensure that purchases did not exceed warrant authority limits.

We reviewed the warrant authorities for five cardholders whose purchase limits were set above the simplified purchase amount of $2,500. Cardholders who are not warranted at a higher amount through the Contracting Officer Certification Program are limited to the simplified purchase amount of $2,500. Our review showed that two of the five cardholders were warranted at amounts that were less than the purchase limits on their purchase cards. One cardholder had a $100,000 purchase limit, but only had a $10,000 warrant authority. During March and April 2004, this cardholder made seven purchases totaling about $265,000. All seven purchases exceeded the cardholder's warrant authority. The second cardholder, whose warrant authority was limited to $25,000, had a purchase limit of $50,000. However, we did not identify any purchases made by this cardholder that were over the warrant authority limit.

Recommended Improvement Action 7. We recommended the VISN Director require the System Director to ensure that purchase limits on purchase cards do not exceed the cardholders' warrant authorities.

The VISN and System Directors agreed with the finding and recommendation and reported that a review of all cardholders' purchase limits and warrant authorities has been completed. New warrants were issued to ensure that purchase limits were consistent with warrant authorities. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 18 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 16, 2004

From: Director, VA Southwest Health Care Network, VISN 18 (10N18)

Subject: **CAP Review of West Texas VA Health Care System, Big Spring, Texas**

To: Director, Dallas Audit Operations Division (52DA)

I concur with the attached facility response on the recommendations and suggestions for improvement contained in the draft Combined Assessment Program review at the West Texas VA Health Care System, Project Number 2004-02293-R6-0387. Comments and action plans are noted in the response. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

(original signed by:)
Patricia A. McKlem

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 16, 2004

From: Director, West Texas VA Health Care System (519/00)

Subject: **CAP Review of West Texas VA Health Care System, Big Spring, Texas**

To: Director, Dallas Audit Operations Division (52DA)

I wish to thank the OIG CAP Survey Team for their professional, comprehensive, impartial and educational survey July 12-16, 2004. I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of the West Texas VA Health Care System (WTVAHCS). I concur with the findings needing improvement and recommendations /suggested improvement actions. Most corrective actions are, in fact, either complete or very near completion.

I am very pleased the surveyors did not have issues or recommendations in four areas including Environment of Care, Equipment Accountability, Moderate Sedation and Quality Management. The WTVAHCS staff is also very proud of the results of the patients surveyed by the OIG and the overall ratings provided. Again, I thank the OIG Team for their comprehensive survey. The collective efforts and expertise of the CAP review team promotes continuous improvement and raises the level of care, safety, and service provided to our nation's heroes, the veteran.

(original signed by:)
LOU ANN ATKINS, MSN, MBA, CHE
Director

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director takes action to: (a) reconcile differences and correct inventory records as appropriate; (b) provide refresher training for SPD personnel, emphasizing the importance of recording receipts accurately and posting distributions promptly; and (c) reduce stock levels to adhere to the 30-day goal.

Concur **Target Completion Date:** 1-31-2005

a) Reconcile differences and correct inventory records as appropriate

IMPLEMENTATION: New Chief of A&MM was on station 8/23/04. Wall-to-Wall inventory was completed in EMS/ENG between 8-23-04 to 8-31-04. All items in EMS/ENG have been entered into GIP inventory. Complete inventory will be completed in Warehouse and SPD by January 31, 2005.

b) Provide refresher training for SPD personnel, emphasizing the importance of recording receipts accurately and posting distributions promptly

IMPLEMENTATION: Training was completed for 100% of SPD staff the week of August 23 - August 27, 2004. Training will be completed at least annually, more often if determined to be needed, and during new employee orientation for any new staff in SPD. To monitor the training's effectiveness, beginning 11/8/2004, the Chief SPD will run the AUTOGEN report on a daily basis and assign each supply technician a random five line items for physical count to verify receipts were recorded accurately and distributions posted promptly. The aggregated results of this monitoring will be reviewed monthly to identify trends in the data. This will be fully completed following complete wall-to-wall inventory in SPD by 1-31-2005.

c) Reduce stock levels to adhere to the 30-day goal

IMPLEMENTATION: During completion of wall-to-wall inventory, PAR levels are being established to assist in achieving the 30-day inventory goal and items are being excessed or returned to vendor for credit. TARGET DATE: 1-31-2005.

Recommended Improvement Action 2. We recommend the VISN Director ensure that the System Director requires that: (a) eligibility and clinic clerks obtain insurance information at the time of treatment; (b) medical care providers adequately document the care provided in veterans' medical records; (c) MCCF personnel identify and bill all billable VA and fee-basis care; and (d) the Fee-Basis Unit forwards the documentation required for billing insurance carriers promptly to MCCF personnel.

Concur **Target Completion Date:** Completed

a) Eligibility and clinic clerks obtain insurance information at the time of treatment

IMPLEMENTATION PLAN: Each time a patient presents to eligibility or clinic clerks, a copy of all insurance cards is obtained and entered into the system. Refresher training including the proper use of the insurance buffer file and how to annotate "NO" insurance coverage on the Pre-Registration software, was conducted for 100% of Community Based Outpatient Clinic Administrative Staff (9 employees) and all Medical Center in-take staff (14 employees) from May 2004 through July 2004. Continued education and emphasis on insurance collection and verification is ongoing by Health Administration Service management. In July 2004 two-hundred nineteen (219) Pre-Registrations were completed as compared to five-hundred forty three (543) Pre-Registrations in October 2004, denoting a 60% increase in productivity. The process was revised so that MCCR Insurance Staff monitors the facility Gains and Losses Report daily to ensure late entry for insurance information for inpatients is verified with the insurance company upon admission rather than only when the insurance buffer file is worked. Reporting of total visits and total number of insurance cards obtained and entered into the system is provided at the Director's Morning Meeting beginning 11-8-2004.

The Detailed Patients with Unidentified Insurance Report is reported to the Intake Staff Supervisor weekly to ensure staff is made aware of areas needing improvement. In addition, new Pre-Registration software is being implemented in each clinic that will require staff to update demographics/insurance information upon check-in of the patient. This information will automatically upload into the current Pre-Registration software, reducing telephone calls and enhancing the supervisor's ability to measure individual performance. In October 2004 this program was activated for two Primary Care Clinics at the Medical Center and one Community Based Out Patient Clinic. The new Pre-Registration software was loaded into the Medical Center training database in August 2004 to begin staff training. This program was adopted by VISN 18 and is mandated for full implementation by December 31, 2004.

b) Medical care providers adequately document the care provided in veteran's medical records

IMPLEMENTATION PLAN: Provider-specific documentation training is ongoing however, to date, all revenue cycle staff were trained and educated on the proper use and selection of "claims tracking non-billable reason" and subsequent follow up with providers April-May 2004.

Report generated for period July 15- July 31, 2004 shows three (3) non-billable events due to insufficient documentation and no documentation. A Reasons Not Billable Report generated for October 15- October 30 shows one (1) non-billable event due to no documentation.

The Reason-Not-Billable report is run bi-weekly to identify newly marked reasons not billable. Providers are contacted to provide documentation. Additional reports have been developed identifying the cause of billing delays on the Out-Patient Non-Service-Connected (ONSC) list. The results of these reports are reviewed by Supervisory staff in Health Information Management and MCCF. Providers identified as consistent outliers are referred to the Compliance Officer for additional training and education. Quarterly summaries from the Reason-Not-Billable and ONSC reports will be provided to the Chief of Staff beginning December 2004. Providers who fail to provide documentation for the same event on two consecutive reports receive notification along with their service chief and the Chief of Staff. In addition, if a provider fails to provide sufficient documentation for the same event on three consecutive reports, the Chief of Staff will be notified for follow up. Repeated incidents of insufficient documentation of medical care provided will be taken into consideration during bi-annual reprivileging reviews.

In the event trends are identified with the medical staff as a whole, education/training will be provided at the monthly Medical Staff meeting.

c) MCCF personnel identify and bill all billable VA and fee-basis care

IMPLEMENTATION PLAN: A Lead Health Information Management System (HIMS) Coder was appointed 10-2004 to provide continuity in this function. HIMS staff is reviewing and coding all inpatient encounters and forwarding encounters with third party insurance to MCCR Staff to be billed. Coding reviews all Fee Basis inpatient claims and verifies that codes are correct or revises the codes that documentation does not support. If there is a discrepancy in codes, the coding clerk notifies Fee Basis immediately and payment is adjusted as appropriate. Once coding is completed, the packet is sent to be filed. The Lead HIMS Coder began conducting formal monthly audits in October 2004 of a minimum of five random inpatient records. Results of the initial audit found no discrepancies in the five records reviewed.

All fee basis claims are reviewed for potential billable episodes for both 1st party and 3rd party. All fee basis claims are reviewed to identify insurance also to ensure claims meet necessary billing criteria.

d) The Fee Basis Unit forward the documentation required for billing insurance carriers promptly to MCCF personnel

IMPLEMENTATION PLAN: This process was revised July 19, 2004 to ensure claims authorized for payment by VA that are determined to have 1st or 3rd Party Reimbursement potential are sent daily from Fee Basis to MCCF Billing Office.

Recommended Improvement Action 3. We recommend the VISN Director ensure that the System Director takes action to: (a) add a list of critical IT equipment to the contingency plan; and (b) review user access at least every 90 days and promptly disable accounts that have not been accessed in 90 days or more.

Concur **Target Completion Date:** Completed

a) Add a list of critical IT equipment to the contingency plan

IMPLEMENTATION PLAN: The contingency plan was updated during the CAP review with a list of critical IT equipment. The contingency plan had the critical equipment listed however it was not specifically labeled as CRITICAL. It was officially corrected on July 19, 2004.

b) Review user access at least every 90 days and promptly disable accounts that have not been accessed in 90 days or more.

IMPLEMENTATION PLAN: A procedure is in place that ensures that users are deactivated automatically in Vista after 90 days of inactivity. Information Security Officer (ISO) reviews the active Vista accounts every 30 days to ensure that this process is effective. Each separating employee (i.e. Retirement, Transfer, termination, etc.) clears through the Information Security Officer's Office prior to leaving the facility. If the employee is unable to clear in person, the Service that the employee belonged to processes the clearing telephonically. Additionally, Human Resources (HR) notifies the ISO of all separating employees. The Local Area Network accounts are reviewed (complete review) monthly. Results from August, September, and October revealed no users remaining on the active user list that should have been removed through the clearance procedure and HR notification procedure.

Recommended Improvement Action 4. We recommend the VISN Director ensure the System Director takes action to: (a) ensure Pharmacy Service personnel complete all 72-hour inventories; and (b) emphasize the importance of maintaining accountability over the disposition of unusable controlled substances.

Concur **Target Completion Date:** Completed

a) Ensure Pharmacy Service personnel complete all 72-hour inventories

IMPLEMENTATION PLAN: The inventories are done every 72 hours although the requirement for this pharmacy (open 5 days per week) is two inventories weekly. The inventories include all controlled substances II through V. Review of the perpetual inventory log is included as part of the monthly unannounced inspections and the Controlled Substance Coordinator reports any missed inventory to the Medical Center Director's (MCD) attention immediately. For the period of July 26 to November 4, 2004, (15 week period) a total of 35 perpetual inventories including II - V were completed out of the 28 required. The week of Labor Day only 2 perpetual inventories were completed.

b) Emphasize the importance of maintaining accountability over the disposition of unusable controlled substances.

IMPLEMENTATION PLAN: Medications held for destruction are in sealed bags with two witness signatures, logged into the controlled Substance Destruction menu in VistA with witness, and follow the chain of custody until turned over for destruction. The Drugs on Hold for Destruction report in VistA and the sealed controlled substances are included in perpetual inventories and unannounced monthly narcotic inspections. The unannounced monthly controlled substance inspections for August, September, and October 2004 did not identify any issues with the drugs on hold for destruction.

Recommended Improvement Action 5. We recommend the VISN Director ensure that the System Director takes action to: (a) provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt; (b) ensure that the CNH review team follows up on deficiencies identified; (c) ensure that each COTR has received required training; and (d) include all required documentation in contract files.

Concur **Target Completion Date:** Completed

a) Provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt

IMPLEMENTATION PLAN: Handbook 1660.3 has been provided to each physician supervisor/manager. As of August 2, 2004, 100% had written acknowledgment of its receipt in their official folder. One new supervisor entered on duty since 8-2-2004 and has signed the acknowledgment, which has been placed in their folder.

b) Ensure that the CNH review team follows up on deficiencies identified

IMPLEMENTATION PLAN: The 6 deficiencies identified by the Safety Officer were reviewed and the appropriate follow up through resolution was documented in the Social Worker CNH file, although a copy was not provided to the Contract File at the time of the CAP inspection. 100% of the deficiencies have been corrected and copies of supporting documentation have been placed in the appropriate Contract file. Individuals with key roles in this function have been replaced since the CAP visit including Chief, A&MM and Chief, Social Work Services. Effective immediately, all CNH inspections/findings/issues are tracked through the CNH Oversight committee until closure.

c) Ensure that each COTR has received required training

IMPLEMENTATION PLAN: COTR Training was provided to 100% of COTRs as of August 1, 2004. This training will be provided to any new COTR prior to appointment. The training will be provided at least annually on a scheduled basis every September. A tracking system has been developed for each contract listing the COTR and training date to be certain the training remains current.

d) Include all required documentation in contract files

IMPLEMENTATION PLAN: 100% of staff was educated regarding the requirements for each contract file. A review was completed of all contract files and all files are current with copies of all required documentation present. A checklist has been developed with the requirements for all new files. A random review of 5 contract files is being conducted monthly to ensure the effectiveness of the process. The results of the audits for September and October noted 100% compliance with requirements.

Recommended Improvement Action 6. We recommend the VISN Director ensure that the System Director: (a) establishes an MOU with the local bulk oxygen vendor; and (b) requires that the bulk oxygen utility system have a minimum of two alarm panels that operate independently.

Concur **Target Completion Date:** 7/15/2005

a) Establish an MOU with the local bulk oxygen vendor

IMPLEMENTATION PLAN: An MOU is signed AND on file effective 11/08/2004.

b) Require that the bulk oxygen utility system have a minimum of two alarm panels that operate independently

IMPLEMENTATION PLAN: The completion of the project for the corrective actions is 7/15/2005.

Recommended Improvement Action 7. We recommend the VISN Director require the System Director to ensure that purchase limits on purchase cards do not exceed the cardholders' warrant authorities.

Concur **Target Completion Date:** Completed

IMPLEMENTATION PLAN: A full-time A/OPC (Purchase Card Coordinator) was selected and began the position 8/16/04. Additionally, the Chief, A&MM was selected and on station 8/23/04. Follow up on the issue identified by the IG was priority to ensure that purchase limits on purchase cards did not exceed the cardholders' warrant authorities. A review of all cardholders, purchase card limits, and warrant authorities was conducted 8/27/2004. There were five cardholders identified with warrant authority. The Chief, A&MM Service issued new warrants to all ensuring purchase limits was consistent with warrant authority. 100% of the card holders received education as required on 8/27/2004. Audits are conducted monthly for purchases exceeding limits. Of the audits for September and October, over 200 purchases were reviewed with a sampling from 100% of purchase card holders with 100% within limits and completed within all VHA requirements.

Overall review of all cardholders will be done yearly to ensure compliance with this and other requirements.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Reducing stock levels would make funds available for other uses.	$44,460
2	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	14,983
	Total	$59,443

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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