Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California

Report No. 04-03359-105 **March 16, 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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Introduction

During the week of November 15–19, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Palo Alto Health Care System (referred to as the health care system). The purpose of the review was to evaluate selected health care system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided fraud and integrity awareness training to 488 employees. After the review, the health care system made the training available on its intranet, and an additional 113 employees received the training on-line.

Results of Review

This CAP review covered 13 areas. The health care system complied with selected standards in the following six areas:

- Accounts Receivable
- Community Nursing Home Contracts
- Environment of Care
- Equipment Accountability
- Pressure Ulcer Clinical Practices
- Service Contracts

We identified the following organizational strengths:

- Clinicians receive unique advanced clinical training in the Patient Safety Center of Inquiry Simulation Center (Simulation Center).
- The Traumatic Brain Injury Unit provides specialized care to active duty patients.

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

- Ensure that prime vendor purchases are monitored and overcharges recovered.
- Reduce Medical Care Collections Fund (MCCF) unbilled outpatient encounters and improve clinical documentation.
- Improve mortality trending and reporting and patient complaint analyses and ensure patients are advised of their rights to file claims when there are adverse outcomes.
- Strengthen controlled substances inspection procedures and pharmacy security.
- Strengthen Government Purchase Card Program controls.
- Ensure that desk audits of part-time physician timekeepers are consistently conducted.
- Ensure that required background investigations are performed for Information Technology (IT) staff in high-risk positions.

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

VISN and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14-23, for the full text of the Directors' comments.) The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Introduction

Health Care System Profile

Organization. The VA Palo Alto Health Care System provides inpatient and outpatient health care services at three divisions located in Palo Alto, Livermore, and Menlo Park, CA; and outpatient care at community-based outpatient clinics in Capitola, Modesto, Monterey, San Jose, Sonora, and Stockton, CA. The health care system is part of Veterans Integrated Service Network (VISN) 21 and serves a veteran population of about 80,000 in a primary service area that includes 10 counties in California.

Programs. All acute care, acute inpatient psychiatry, spinal cord injury, rehabilitation medicine, blind rehabilitation, and hospice services are located at the Palo Alto Division. The Livermore Division, 40 miles east of Palo Alto, provides sub acute and geriatric inpatient services and primary, subspecialty, and ancillary outpatient services. The Menlo Park Division, 7 miles north of Palo Alto, provides inpatient and outpatient comprehensive domiciliary care and long-term geriatric, mental health, and Post Traumatic Stress Disorder care. The health care system has a total of 921 hospital beds at the 3 divisions.

Affiliations and Research. The health care system is affiliated with the Stanford University School of Medicine and supports 563 medical resident positions. The health care system is also affiliated with several colleges to provide clinical training opportunities for allied health, nursing, and optometry students. In Fiscal Year (FY) 2004, the research program had 638 projects and a budget of $50.4 million. Important areas of research include Alzheimer's disease, geriatrics, Human Immunodeficiency Virus (HIV), mental health, schizophrenia, and spinal cord regeneration.

Resources. In FY 2003, the health care system's medical care expenditures totaled $432.4 million. The FY 2004 medical care budget was $470.6 million, an 8.8 percent increase over FY 2003 expenditures. This increase included funds for equipment, nonrecurring maintenance, and special programs such as the HIV Center; the Mental Illness Research, Education, and Clinical Center; the Program Evaluation and Research Center; and the Simulation Center. FY 2004 staffing was 2,854.1 full-time equivalent employees (FTE), including 195.1 physician and 979.2 nursing FTE.

Workload. In FY 2004, the health care system treated 53,955 unique patients, a 4.6 percent increase over FY 2003. Health care system officials attributed the increase to increased capacity at the community-based outpatient clinics and use of advanced clinic access principles. The health care system's inpatient care workload totaled 10,360 discharges, and the average daily census was 775.9. The outpatient workload was 555,180 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, 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.

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 13 activities:

Accounts Receivable	Medical Care Collections Fund
Community Nursing Home Contracts	Part-Time Physician Time and Attendance
Controlled Substances Accountability	Pressure Ulcer Clinical Practices
Environment of Care	Procurement of Supplies
Equipment Accountability	Quality Management
Government Purchase Card Program	Service Contracts
Information Technology Security	

The review covered facility operations for FYs 2001-2005 (through October 2004), and was done in accordance with OIG standard operating procedures for CAP reviews.

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

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, and 629 employees responded. We also

interviewed 30 patients during the review. We discussed the survey and interview results with health care system managers.

During the review, we presented 6 fraud and integrity awareness briefings for 488 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery. The health care system also developed an on-line version of the OIG's fraud and integrity awareness briefing for staff who were unable to attend during the week of the CAP review. As of February 7, 2005, 113 health care system employees had reviewed the fraud and integrity awareness briefing materials on-line.

Follow-Up on Previous CAP Recommendations

As part of this review, we followed up on recommendations from the prior CAP review of the health care system (*Combined Assessment Program Review of the VA Palo Alto Health Care System, Report No. 00-02063-52, February 26, 2001*). In October 2000, the OIG found that the VISN and health care system needed to improve contracting processes for clinical service contracts and sharing agreements and the utilization of radiation services contracts. Our current CAP review found that documentation for clinical services contracts had improved, a sharing agreement had been renegotiated, and patients were being screened to determine if they could receive radiation services from contractors close to their homes. The VISN and Health Care System Directors had adequately addressed the recommendations and conditions cited in the prior CAP report.

Results of Review

Organizational Strengths

The Simulation Center Provides Advanced Clinical Training. The Simulation Center is a key tool for patient safety education, advanced clinical training, and research. In 1986, the Simulation Center pioneered patient simulator clinical training by developing a hands-on patient simulator. Course participants practice in highly realistic simulations involving interaction with members of an operating room or crisis team. In addition to medical skills and knowledge, the simulation training stresses leadership, teamwork, and decision making skills. Since 1989, the Simulation Center has provided training to more than 1,000 clinicians in anesthesia, intensive care, and emergency medicine. In 2003, the Simulation Center's Director received the David H. Worthen Award for Academic Excellence. This annual award recognizes a Veterans Health Administration (VHA) employee who has made a major contribution of national significance to education in the health professions.

Traumatic Brain Injury Unit Serves Active Duty Military Personnel. The Traumatic Brain Injury Unit is one of four facilities in VA that treats active duty military personnel who have sustained brain injuries. The unit serves patients from the western United States and Guam and operates 12 beds in the health care system's rehabilitation ward. The unit treats patients with a comprehensive range of physical, cognitive, and social interventions and also provides compensatory strategies for the patients and their relatives. As of November 2004, the unit had treated 38 active duty military personnel.

Opportunities for Improvement

Procurement of Medical and Prosthetic Supplies – Prime Vendor Prices Should Be Monitored and Overcharges Recovered

Conditions Needing Improvement. The health care system needed to ensure that the VISN prime vendor charged the correct prices for supplies. On September 1, 2000, the VISN contracted with a prime vendor to provide a wide range of medical and prosthetic supplies for all health care facilities in the VISN. The contract stipulated that whenever possible the prime vendor would not procure supplies from open market sources and instead would use four preferred lower priced sources—VA national contracts, VA national blanket purchase agreements (BPAs), Federal Supply Schedule (FSS) contracts, and VA local contracts. Under the contract, the ceiling prices for supplies were the prices available from these lower cost sources plus a 3.5 percent distribution fee.

To determine if the health care system purchased medical and prosthetic supplies effectively, we selected a judgment sample of 20 supply products and reviewed purchases of these products for the 6-month period April–September 2004. The 20 products included 10 medical products (such as anti-embolism stockings and skin closures) and 10 prosthetic products (such as continuous positive airway pressure machines and nebulizers). During the review period, the health care system purchased 17 of the 20 products.[1] For the 17 products, the health care system made 1,043 purchases with a total cost of $223,166. Of these purchases, 979 with a total cost of $94,556 (42.4 percent) were made from the prime vendor and 64 with a total cost of $128,610 (57.6 percent) were made from other vendors.[2]

For the 64 purchases from other vendors, the health care system effectively used national contract and BPA sources and paid correct prices. However, 361 (36.9 percent) of the 979 prime vendor purchases had overcharges totaling $2,383 (2.5 percent of the $94,556 total prime vendor purchases). This problem occurred because the prime vendor did not bill the health care system the correct prices and did not always procure supplies from the best sources.

Overcharges from Not Billing Correct Prices. Of the $2,383 overcharges, $2,042 (85.7 percent) occurred because the prime vendor billed incorrect prices. These prices exceeded the prices available from preferred sources, such as VA national BPAs and FSS contracts, plus the 3.5 percent distribution fee. The overcharges ranged from 2.0 to 161.9

[1] The 20 products were selected for a proposed OIG audit that will focus on the supply purchasing practices of VA medical facilities. These practices will be evaluated as part of selected CAP reviews conducted during FY 2005, and the results will be summarized in an audit report. The three products that the health care system did not purchase were regular disposable scalpels, closed circuit televisions, and portable ramps.

[2] The cost of prime vendor purchases was less than the cost of other vendor purchases because 54 of the 64 other vendor purchases were for 5 high-cost prosthetic products not covered by the prime vendor contract.

percent of preferred source prices. The following example illustrates this type of overcharge:

> **Anti-Embolism Stockings.** During the review period, the health care system purchased 80 pairs of medium-sized, regular knee length anti-embolism stockings from the prime vendor at a price of $4.74 per pair, for a total cost of $379.20. The prime vendor purchased the stockings from the correct BPA source but did not charge the correct price to the health care system. The correct price was $1.75 per pair, so the correct prime vendor contract price was $1.81 per pair ($1.75 per pair + $.06 distribution fee). The health care system did not identify the $2.93 per pair overcharge and overpaid the prime vendor $234.40, or about 161.9 percent more than the correct cost of $144.80 (80 pairs x $1.81 correct contract price = $144.80).

Overcharges from Not Using the Best Source. Of the $2,383 in overcharges, $341 (14.3 percent) occurred because the prime vendor did not use the best source to purchase three other sizes of anti-embolism stockings.[3] The prime vendor should have procured these stockings from a national BPA source at a cost of $900 and should have charged the health care system $932 ($900 cost + $32 distribution fee). However, the prime vendor charged the health care system $1,273 (including the distribution fee) because the stockings were procured from higher priced FSS and open market sources. Health care system staff did not notice this and as a result overpaid the prime vendor $341, or 36.6 percent more than the correct amount ($341 overcharge ÷ $932 correct cost = 36.6 percent).

Both types of overcharges occurred because the Chief of Acquisition and Materiel Management was not monitoring prime vendor prices. The $2,383 in overcharges was 2.5 percent of the $94,556 in prime vendor purchases for the sampled products. The 2.5 percent overcharge may seem small, but applying this rate to the health care system's $4.2 million in FY 2004 prime vendor purchases equates to estimated total overcharges of $105,000.

Because the prime vendor contract stipulated that product prices would be the same VISN-wide, there is a high probability that all health care facilities in the VISN were overcharged. To estimate the FY 2004 VISN-wide overcharges, we applied the 2.5 percent overcharge rate for the sampled products to the $10.4 million cost of VISN prime vendor purchases in FY 2004. This yielded estimated FY 2004 overcharges of $260,000. In addition, because neither the health care system nor the VISN monitored prime vendor prices, overcharges could have occurred since the inception of the contract in September 2000. To estimate the potential VISN-wide overcharges for FYs 2001-2004, we applied

[3] Each of the 20 sampled products included broad product lines. Within these lines, there were many specific brands, models, and types of products available from multiple sources. For example, medium-sized, regular knee length stockings were procured from the best source but medium-sized, regular thigh length stockings were not.

the 2.5 percent overcharge rate to the $36.1 million cost of FY 2001–2004 VISN-wide prime vendor purchases. This yielded estimated overcharges of $902,500.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the health care system and all other VISN health care facilities: (a) review FYs 2001–2004 prime vendor purchases for price overcharges, (b) pursue recovery of all identified overcharges, and (c) monitor future prime vendor prices to ensure they are correct.

The VISN Director agreed with the findings and recommendations and reported that the health care system will review all prime vendor purchases for overcharges. If the health care system's review identifies significant overcharges, the VISN will initiate a review of all FYs 2001-2004 prime vendor purchases for all VISN 21 health care facilities and ensure facilities monitor the correctness of future prime vendor prices. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Insurance Verification, Billing, and Clinical Documentation Needed Improvement

Conditions Needing Improvement. MCCF managers needed to verify insurance information, promptly bill for fee-basis care, reduce unbilled claims, and ensure clinical documentation was sufficient to support billings. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the health care system collected $15.14 million (96 percent of its FY 2004 collection goal of $15.77 million), but we identified four areas that needed improvement.

Insurance Verification. During August 2004, MCCF staff had not recorded insurance information for 168 veterans in the health care system's MCCF records. Our review of a judgment sample of MCCF records for 10 veterans found that registration clerks had not verified 1 veteran's insurance information or annotated 4 veterans' records to show they did not have insurance.

Fee-Basis Billing. From October 1, 2003, to August 30, 2004, the health care system paid 5,812 fee-basis claims, totaling about $1.56 million, to non-VA clinicians for the care of veterans with health insurance. To determine if the health care system had billed the insurance carriers for this care, we reviewed a judgment sample of 15 fee basis claims totaling $111,101. Our review found that two bills totaling $32,569 had been issued and six fee basis claims totaling $41,439 were not billable to the insurance carriers under the terms of the insurance plans. During our review, MCCF staff created bills totaling $37,093 for the remaining seven billable fee-basis claims, but four of these bills, totaling $21,955, had to be subsequently canceled because they exceeded the insurance carriers' billing time frames. The MCCF Manager stated that a staffing shortage in FY 2004 had

created a billing backlog but additional staff would be available in FY 2005 to reduce the backlog. Using the health care system's FY 2004 third-party collection rate of 23 percent, MCCF staff could have potentially collected about $8,531 if all seven claims had been promptly billed ($37,093 x 23 percent).

Unbilled Claims. The November 18, 2004, "Unbilled Amounts" report showed that the health care system had 33,954 outpatient encounters, totaling about $9.12 million, that had not been processed for billing. We reviewed a judgment sample of 10 unbilled encounters, valued at $41,288, with service dates more than 1 year old. Six of these encounters, valued at $36,877, were not billable. The remaining four encounters, valued at $4,411, were no longer billable because the billing time frames specified by the insurance carriers had been exceeded. MCCF staff could have collected about $1,015 if the four encounters had been promptly billed ($4,411 x 23 percent collection rate).

Clinical Documentation. VHA policy requires clinicians to enter documentation into the medical record at the time of each outpatient encounter so that MCCF staff can bill insurers for the care provided. We reviewed medical record and MCCF billing documentation for a judgment sample of 50 outpatient encounters during the period March–August 2004 to determine if insurers had been billed. Of the 50 encounters, 2 had already been billed and collected and 10 had no collection potential because they were not billable under the terms of the veterans' insurance plans. The remaining 38 encounters, valued at $115,202, had not been billed because of insufficient or missing clinical documentation.

- Thirty encounters, valued at $107,408, had not been billed because clinicians did not provide sufficient clinical documentation. At the time of the CAP review, Medical Records staff requested that these clinicians supply the additional clinical documentation required for these bills. As a result of our review, Medical Records staff obtained information for 13 of the 30 encounters and issued bills totaling $53,419. The Compliance Officer and the Medical Records Manager stated that they were working with the responsible clinicians to obtain additional clinical documentation for the other 17 encounters. MCCF staff could potentially collect about $24,704 for these 30 encounters ($107,408 x 23 percent collection rate).
- Eight encounters, valued at $7,794, had not been billed because clinicians either did not document the encounters or did not document their supervision of the residents who provided the care. As a result of our review, the Compliance Officer implemented a new procedure requiring Clinical Service administrative officers to follow up with clinicians to obtain the needed information and ensure that all encounters are documented. MCCF staff could have potentially collected about $1,793 if the clinicians had properly documented the eight encounters ($7,794 x 23 percent collection rate).

Better clinical documentation and improved billing procedures would have resulted in increased collections. We estimated that the health care system could have increased collections by $36,042 [$37,093 + $4,411 + $107,408 + $7,794 x (23 percent collection)].

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) MCCF staff verify and record insurance information for all veterans, (b) the MCCF Manager improves procedures to identify and bill for fee-basis care, (c) the MCCF Manager implements monitoring procedures to ensure that bills are issued promptly, and (d) clinicians promptly and completely document all patient encounters in the medical records.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that a Patient Scheduling Unit had been established to collect insurance information from veterans when they make appointments. The health care system also has addressed staffing shortages in its Fee Basis Department that caused a backlog in fee basis billings during FY 2004. To address problems related to the promptness of billings and medical documentation, the health care system has implemented daily quality reviews and tracking and follow-up procedures for outpatient encounters with missing documentation and signatures; provided one-on-one training on the preparation of timely and complete medical documentation; and conducted a local audit to identify trends in medical documentation deficiencies. The improvement plans are acceptable, and we will follow up on the planned actions until completed.

Quality Management – Mortality Reviews, Patient Complaint Analyses, and Adverse Outcome Discussions Needed Improvement

Conditions Needing Improvement. The QM program was generally effective but certain QM reviews, analyses, and processes needed to be strengthened. Appropriate review structures were in place for 9 of the 12 program areas reviewed, but the 3 other areas needed improvement.

Mortality Reviews. The QM Coordinator and clinicians needed to improve the trending of mortality data. Clinicians reviewed individual deaths in considerable detail and trended health care system-wide mortality data. However, VHA directives also require the trending of deaths by ward, service, shift, and provider.

Patient Complaints Analysis. The Patient Complaints Program Coordinator needed to expand data analyses in the patient complaints program to identify trends and opportunities for improvement. VHA directives require that patient advocates aggregate complaints and present trended reports to senior managers and patient care providers. For FY 2004, patient complaint reports were limited to broad topic areas, such as timeliness of care and employee courtesy. In addition, these limited data analyses were not presented in any clinical forum, such as the Medical Executive Board.

Adverse Outcome Discussions. When clinical managers discussed serious adverse outcomes with patients, they needed to advise the patients of their rights to file claims and document these notifications in the patients' progress notes. When such outcomes occur as a result of patient care, VHA directives and health care system policy require staff to discuss the situations with the patients and to inform them of their rights to file tort or benefits claims. During the period January–September 2004, responsible clinicians and health care system administrative staff discussed adverse outcomes with four patients but did not advise them of their rights to file claims.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) the QM Coordinator conducts comprehensive mortality trending and reporting, (b) the Patient Complaints Program Coordinator conducts critical analyses of patient complaint data and present the results in a clinical forum, and (c) the Chief of Staff advises patients who experience adverse outcomes of their rights to file claims and document this in the patients' progress notes.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that staff would review, trend, and report mortality and patient complaints data to the Medical Executive Board and Executive Council. The health care system's Risk Manager has been assigned responsibility for advising patients and their families of the right to file claims and documenting these discussions when there are adverse clinical outcomes. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Inspection Controls and Pharmacy Security Needed Improvement

Condition Needing Improvement. The Controlled Substances Coordinator (CSC) and Pharmacy Service managers needed to improve controls over the controlled substances inspection program and pharmacy security. VHA policy requires Pharmacy Service staff to manage medications, particularly controlled substances, to ensure patient safety and prevent diversion. In addition, VA policy requires specific physical safeguards to ensure pharmacy security. Our review found that controlled substances inventories were being performed, controlled substances inspectors were properly trained, and employee access controls in the pharmacy were effective. However, we identified two areas that needed improvement.

Unannounced Controlled Substances Inspections. VHA policy requires health care facilities to conduct monthly unannounced inspections for all wards and storage areas containing controlled substances and to review documentation related to the receipt and inventory of controlled substances. In addition, VHA policy states inspection duties should be rotated among the trained inspectors and no inspector should perform more than six inspections within a 12-month period. Our review found that only 174 of the

270 (64 percent) required monthly inspections were performed from September 2003 to August 2004. In addition, 19 inspectors had performed more than 6 inspections during this period. A new CSC, appointed in August 2004, had begun implementing revised inspection procedures that address these deficiencies.

Pharmacy Security. VA policy contains several requirements for preventing theft and diversion of controlled substances from pharmacies. Our review found that the pharmacy did not have a motion intrusion detection system and that the outpatient dispensing window and supporting wall were not reinforced as required by VA policy. The Acting Chief of Pharmacy Service provided documentation to show the scheduled installation of a motion intrusion detection system and stated that the health care system was in the process of negotiating a contract to construct a new dispensing window and supporting wall.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) the CSC continues the implementation of revised controlled substances inspection program procedures and (b) the Acting Chief of Pharmacy Service continues correcting the deficiencies in pharmacy security.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the CSC was continuing to implement revised controlled substances inspection procedures. The new Chief of Pharmacy is also continuing to correct identified deficiencies in pharmacy security. A motion intrusion detection system and new outpatient pharmacy window have already been installed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Needed To Be Strengthened

Conditions Needing Improvement. Fiscal Service managers and the Purchase Card Coordinator (PCC) needed to strengthen controls over the Government Purchase Card Program. The PCC reviewed random samples of transactions and the Assistant Chief of Fiscal Service conducted weekly follow-ups for timely reconciliations, performed approval certifications, and prepared monthly reconciliation reports. In addition, cardholders and approving officials were properly trained, and warrants were issued to cardholders whose single purchase limits exceeded $2,500. However, we identified three deficiencies that needed to be corrected.

Separation of Duties. VHA policy requires a clear separation of duties in authorizing purchases, making purchases, and recording purchase card transactions. The health care system's Dispute Officer, who was responsible for monitoring disputed payments, credits, and billing errors, was also a cardholder, which did not comply with VHA policy.

Limit on Micro-Purchases. VHA policy requires the use of Government purchase cards for micro-purchases that do not exceed $2,500. We reviewed a judgment sample of 5 purchases, totaling $24,875, and found that 4 cardholders circumvented the $2,500 purchase limit by splitting 4 purchases, totaling $19,573, into 12 separate purchases.

Sole Source Purchases. The Federal Acquisition Regulation requires cardholders to promote competition for purchases that exceed $2,500 through the solicitation of at least three price quotes from vendors when the purchase cannot be made from Government suppliers. We reviewed a judgment sample of five purchases, totaling $46,294, and found two prosthetic purchases, totaling $14,636, that did not have the required price quotes. The cardholders had not sought competition or documented justifications for the sole source purchases that exceeded the $2,500 threshold.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) the Dispute Officer not be a cardholder, (b) the PCC establishes controls to prevent cardholders from splitting purchases to circumvent micro-purchase limits, and (c) approving officials ensure that requirements promoting competition are met for purchases exceeding $2,500.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the health care system would reassign the Dispute Officer's responsibilities to a staff person who was not a cardholder or approving official. In addition, the PCC and health care system management have issued new policies that implement a ratification process for purchases that have been split to avoid the $2,500 threshold, and cardholder performance standards that require strict adherence to purchasing guidelines and competition requirements. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Part-Time Physician Time and Attendance – Timekeeper Desk Audits Should Be Completed

Condition Needing Improvement. Fiscal Service managers needed to consistently perform desk audits of part-time physician timekeepers. As of October 2004, the health care system had 51 part-time physicians, with 12 timekeepers recording their time and attendance. We evaluated the management of part-time physicians by reviewing physician and timekeeper time and attendance records, interviewing health care system managers and part-time physicians, and physically verifying part-time physician attendance. We identified one deficiency that needed to be corrected.

VA policy requires timekeepers to receive semiannual desk audits to ensure that they are properly recording time and attendance. At the health care system, Fiscal Service staff are responsible for performing these audits. To determine if timekeeper desk audits were done, we reviewed FYs 2003 and 2004 desk audit records for 12 timekeepers. Fiscal

Service staff performed only 11 of the required 48 audits during the 2-year period, with 9 of the 11 audits (82 percent) being completed within the last 6 months.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director requires Fiscal Service to perform timekeeper desk audits in accordance with VA policy.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that a timekeeper desk audit schedule had been established to achieve 100 percent compliance with VA policy. The improvement plan is acceptable, and we will follow up on the planned action until it is completed.

Information Technology Security – Background Investigations Needed To Be Completed

Condition Needing Improvement. Human Resources Management (HRM) Service managers needed to ensure that Information Resources Management Service (IRMS) staff in high-risk positions had appropriate background investigations. VA policy requires that employees have full background investigations covering a 10-year period if they are in high-risk positions where a high degree of public trust is required for them to carry out critical responsibilities. We reviewed records pertaining to a judgment sample of eight IRMS staff and found that four, including the Chief of IRMS and the Alternate Information Security Officer, did not have completed background investigations. HRM Service staff had requested the background investigations, but did not follow up with the VA Office of Security and Law Enforcement to ensure that the investigations had been completed.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Health Care System Director requires HRM Service staff to follow up with the VA Office of Security and Law Enforcement on requested background investigations to ensure investigations are completed for IRMS staff in high-risk positions.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that HRM Service has developed operating procedures to ensure appropriate sensitivity designations are assigned to all staff. To document this process, HRM Service has developed a log that includes the date that the background investigation package was submitted and follow-up was conducted with the VA Office of Security and Law Enforcement. Background investigation packages have been submitted for all IRMS staff in high risk positions and follow-up will be performed monthly. The improvement plan is acceptable, and we will follow up on the planned action until it is completed.

Appendix A

VISN 21 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 11, 2005

From: VISN 21 Director

Subject: **Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Los Angeles Audit Operations Division (52LA)
Director, Management Review Office (10B5)

1. I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of the VA Palo Alto Health Care System (VAPAHCS). I carefully reviewed the report, as well as my notes from the exit briefing I attended on November 19, 2004. In addition, I discussed the findings and recommendations with senior leadership at VAPAHCS and the VISN 21 office.

2. In brief, I concur with all of the conditions needing improvement and recommended improvement actions. The implementation plan showing specific corrective actions is provided in Appendicies A and B. As you will note, several actions have already been completed and the remainder are well underway.

3. I am pleased that you noted the organizational strengths of the patient safety simulation center and Traumatic Brain Injury Unit. I am very proud that questionnaires and patient interviews documented a high level of patient satisfaction.

4. In closing, I would like to express my appreciation to the CAP review team. The team members were diligent, professional and comprehensive. In addition to audit and oversight activities, the CAP team provided several

educational sessions (e.g., fraud and abuse awareness) that were helpful. The collective efforts and insights of the CAP review team have helped to improve our clinical activities and business practices at VAPAHCS.

(original signed by:)

Robert L. Wiebe, M.D., M.B.A.

VISN 21 Director's Comments to Office of Inspector General's Report

The following VISN 21 Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the health care system and all other VISN health care facilities: (a) review FY 2001–2004 prime vendor purchases for price overcharges, (b) pursue recovery of all identified overcharges, and (c) monitor future prime vendor prices to ensure they are correct.

Concur **Target Completion Date:** 3/01/2005

I concur that all VISN prime vendor purchases for Fiscal Years 2001 through 2004 (FY01-FY04) may need to be reviewed for overcharges. However, since the recommendation is based on a relatively small sample size, I propose that initially all of the prime vendor purchases for VA Palo Alto Health Care System be reviewed for overcharges. If this initial review determines that the overcharges are significant, I will proceed with a review of the FY01-FY04 prime vendor purchases for all facilities in VISN 21 and ensure all facilities establish monitors to ensure the correctness of future prime vendor prices.

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 11, 2005

From: Health Care System Director

Subject: **Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Los Angeles Audit Operations Division (52LA)
Director, Management Review Office (10B5)

1. VAPAHCS appreciates the opportunity to review this draft report. We also very much appreciate Ms. Mah's willingness to work collaboratively with us on the final content of this report.

2. Any questions regarding the response to the recommendations to this report may be directed to me by calling 650-858-3939.

(original signed by:)
Elizabeth Joyce Freeman

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

The following Health Care System 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 2. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) MCCF staff verify and record insurance information for all veterans, (b) the MCCF manager improves procedures to identify and bill for fee-basis care, (c) the MCCF manager implements monitoring procedures to ensure that bills are issued promptly, and (d) clinicians promptly and completely document all patient encounters in the medical records.

Concur **Target Completion Date:** 9/30/05

(a) MCCF staff verify and record information for all veterans.

VAPAHCS staff recognizes that unverified insurance information holds the potential of lost revenue, and works diligently to ensure front-line staff obtain the insurance information. To encourage staff to perform this important task, VAPAHCS has a successful Insurance Incentive Program that provides a cash incentive for every new insurance company identified and properly entered into our system. VAPAHCS has established a designated Patient Scheduling Unit designed to collect insurance information from each veteran contacting VAPAHCS for an appointment.

According to guidelines established by VA Central Office, VAPAHCS is well within the established standards for insurance identification. The VACO "acceptable level" is 3.0% and the "exceptional level" is below 1.0%. VAPAHCS' cumulative numbers for FY04 were .76% and are currently at .88% cumulative for FY05, both of which are within the exceptional area for performance in this standard.

Additionally, for the VA performance measure for "Patients Treated with Insurance Questions Unanswered", the facility had .10% for FY04 cumulative and is currently at .09% for FY05 cumulative. These scores also represent exceptional performance and are well below the allowable 3.0% as well as the exceptional score of 1.0%.

Included for your review are the VACO performance charts.

(b) MCCF manager improves procedures to identify and bill for fee-basis care.

VAPAHCS concurs that the MCCF department needs to timely identify and bill for fee-basis care. In 2004, the failure of MCCF to accomplish this was directly attributable to a significant lag time in processing payment of Fee Basis claims by the Fee Basis Department due to staffing shortages. The Chief, Business Office identified this concern in January 2004 and immediately implemented an action plan that resolved the backlog by November 2004. Processing of fee claims is currently within acceptable time standards, and MCCF is now able to meet requirements for billing for fee-basis care.

(c) MCCF manager implements monitoring procedures to ensure that bills are issued promptly.

Concur with OIG assessment that VAPAHCS needs to improve monitoring to ensure that bills are issued promptly. The largest identifiable problem impacting our ability to bill promptly is that encounters are not closed timely. A plan to correct the issue on untimely closing of encounters has been initiated by the Compliance Committee. (See paragraph "d" below.)

The VAPAHCS Business Office monitors billing practices utilizing a variety of management reports in the VistA computer system. The Unbilled Accounts Report is most commonly utilized, and a review of unbilled accounts for January 2004 indicates improvement since the OIG visit in November. Additionally, VAPAHCS' current billing productivity is 6,000 claims per month, compared to an average of 4,600 claims per month for FY 2004.

NOTE: January 2004 data was reviewed as that is the last period that is officially no longer billable.

(d) Clinicians promptly and completely document all patient encounters in the medical records.

VAPAHCS concurs with the OIG assessment that clinicians promptly and completely document all patient encounters and facilitate billing of outpatient visits. Our action plan includes the following:

1. VAPAHCS has instituted "real-time" quality reviews where all outpatient encounters with missing documentation or missing signatures or counter-signatures are tracked daily by Health Information Management staff. Subsequently, incomplete and missing records are sent to service level Administrative Officers for immediate intervention and response by providers. Providers are given 5 days to complete documentation (Note: This will also address the timeliness for closing encounters, which impacts the Unbilled Report.).

2. VAPAHCS also initiated one-on-one training sessions (beginning with Primary Care Providers on February 1, 2005) to heighten the importance of complete medical documentation as well as timely completion of patient encounter information.

3. Finally, VAPAHCS established a new local audit within the Business Office to generate the "Reason Not Billable" report on a monthly basis and identify trends with specific providers as well as capture potential deficiencies in medical documentation.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the QM Coordinator conduct comprehensive mortality trending and reporting, (b) the Patient Complaints Program Coordinator conduct critical analyses of patient complaint data and present the results in a clinical forum, and (c) the Chief of Staff advise patients who experience adverse outcomes of their rights to file claims and document this in the patients' progress notes.

Concur **Target Completion Date:** 3/31/05

(a) Mortality Trending and Reporting: The Quality Manager or designee screens all deaths occurring in the facility. All deaths occurring within the previous 24 hours are discussed at morning weekday senior management report. Individual services will review individual deaths in service's morbidity and mortality conferences. Quality management will prepare a report for the Medical Executive Board and Executive Council on a quarterly basis. The 2004 mortality report will be reported to the Medical Executive Board and Executive Council by March 31, 2005.

(b) Patient Complaints Analysis: The new Patient Advocate (hired 12/20/04) will be trained on the Patient Service Tracking software package by March 31, 2005. All complaints will be logged into the system starting March 1, 2005. Reports will be generated, analyzed, and presented to Executive Council and Medical Executive Board on a quarterly basis.

(c) Adverse Outcome Discussions: Clinical staff will be reeducated that the Risk Manager needs to be contacted immediately in the event of an adverse clinical outcome. The Risk Manager will contact patient and/or family to inform them of their legal rights to file a tort or 1151 claim. Documentation of this activity will be maintained by the Risk Manager.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the CSC continues the implementation of revised controlled substances inspection program procedures and (b) the Acting Chief of Pharmacy continues correcting the deficiencies in pharmacy security.

Concur **Target Completion Date:** 2/4/05

(a) Controlled Substances Inspection: The CSC continues to implement the revised controlled substances inspection procedures.

(b) The New Chief of Pharmacy continues to correct the deficiencies in pharmacy security. The outpatient pharmacy dispensing window at the Palo Alto Division (PAD) was installed on February 4, 2005. In addition, the motion intrusion detection system at PAD was installed on February 4, 2005.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the Dispute Officer not be a cardholder, (b) the PCC establish controls to prevent cardholders from splitting purchases to circumvent micro-purchase limits, and (c) approving officials ensure that requirements promoting competition are met for purchases exceeding $2,500.

Concur **Target Completion Date:** 2/1/05

(a) VAPAHCS agrees to redesignate the disputes offices to an individual who does not possess a government purchase card or is an approving official.

(b) The PCC has, through the Associate Director and Chief of Staff, issued performance standards to all purchase card holders requiring PC holders to strictly follow purchasing guidelines and also has implemented the new policy requiring the ratification of purchases found to be split in order to circumvent the $2,500.00 threshold.

(c) The PCC, through the Associate Director and Chief of Staff, has issued performance standards to all purchase card approving officials requiring strict observance of the competition in contracting act.

These actions have all been accomplished.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Health Care System Director requires Fiscal Service to perform timekeeper desk audits in accordance with VA policy.

Concur **Target Completion Date:** 9/30/05

Concur with this recommendation. As noted by the OIG examiner, VAPAHCS staff completed 82 percent of the audits during the period six months prior to the audit. A timekeeper desk audit schedule has been established to achieve 100 percent compliance.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Health Care System Director requires HRM staff to follow up with the VA Office of Security and Law Enforcement on requested background investigations to ensure investigations are completed for IRMS staff in high-risk positions.

Concur **Target Completion Date:** 2/1/05

HRM staff developed an internal standard operating process to ensure that the appropriate sensitivity designations are assigned to all positions, inclusive of IRMS staff. They established a log that documents the process, to include the dates the investigation package was submitted to and followed-up with the VA, Office of Security and Law Enforcement. All IRMS high risk positions have now been submitted for an investigation, with follow-up on a monthly basis, as a matter of standard practice.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds	Questioned Costs
1	Better use of funds through the monitoring of VISN prime vendor supply prices and recovery of overcharges.		$902,500
2	Better use of funds through improved MCCF billing and documentation procedures.	$36,042	
	Total	$36,042	$902,500

OIG Contact and Staff Acknowledgments

OIG Contact	Janet C. Mah (310) 268-4335
Acknowledgments	Daisy Arugay Carin Childress Frank Giancola Gregory Gladhill Tae Kim Pauline Murano Debra Persley Michael Seitler T. Maurice Smith Vishala Sridhar Julie Watrous Wilma Wong

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