Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the South Texas Veterans Health Care System San Antonio, Texas

Report No. 05-00222-111 **March 25. 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 December 6–10, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the South Texas Veterans Health Care 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 357 employees. The health care system is part of Veterans Integrated Service Network (VISN) 17.

Results of Review

This CAP review covered 12 areas. The health care system complied with selected standards in the following eight areas:

- Controlled Substances
- Emergency Preparedness
- Environment of Care
- Government Purchase Card Program
- Patient Waiting Times
- Pressure Ulcer Clinical Practices
- Procurement of Supplies
- QM Program

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

- Managers implemented a comprehensive patient safety program.

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

- Strengthen service contract controls by requesting preaward audits when required.
- Strengthen supply inventory management by maintaining accurate supply records and reducing stock levels.
- Increase Medical Care Collections Fund (MCCF) collections by improving documentation and billing procedures.
- Strengthen timekeeping controls by ensuring that part-time physicians perform VA duties during scheduled work hours and record their hours worked on subsidiary time sheets, all required timekeeper desk audits are performed, and all timekeepers receive annual refresher training.

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

VISN 17 and Health Care System Director Comments

The VISN 17 and Health Care System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 9–14 for the full text of the Directors' comments.) We will follow up on the implementation of planned improvement actions.

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

Introduction

Health Care System Profile

Organization. The health care system includes the Audie L. Murphy Memorial Veterans Hospital in San Antonio, TX, the Kerrville VA Medical Center (VAMC) in Kerrville, TX, and five satellite clinics in Corpus Christi, Laredo, McAllen, San Antonio, and Victoria, TX. Outpatient care is also provided at eight community-based outpatient clinics in Alice, Beeville, Brownsville, Harlingen, Kingsville, New Braunfels, San Antonio, and Uvalde, TX. The health care system is part of VISN 17 and serves a veteran population of about 320,000 residing in 63 counties in Texas.

Programs. The Audie L. Murphy Memorial Veterans Hospital provides acute medical, surgical, psychiatric, geriatric, and primary care services. The hospital houses the only National Institutes of Health-sponsored inpatient clinical research center in VA, and the Geriatric Research, Education, and Clinical Center has been designated a Center of Excellence by the Veterans Health Administration (VHA). The Kerrville VAMC provides primary, acute medical, and long-term care services. The health care system has 540 operating beds, including 270 acute care beds, 244 nursing home beds, and 26 psychiatric care beds.

Affiliations and Research. The health care system is affiliated with the University of Texas Health Science Center and supports 176 resident positions. In Fiscal Year (FY) 2004, the health care system's research program had 695 projects and a budget of $8.7 million. Important areas of research included aging, nephrology, and infectious diseases.

Resources. The health care system's medical care expenditures totaled $390 million in FY 2004. The FY 2005 medical care budget is $410 million. In FY 2004, the health care system had 2,829 full-time equivalent employees (FTE), which included 178 physician FTE and 508 nursing FTE.

Workload. The health care system treated 71,010 unique patients in FY 2004. Inpatient workload totaled 11,247 discharges in FY 2003 and 10,916 discharges in FY 2004. The average daily patient census in FY 2004 was 203 for acute care and 197 for nursing home care. The outpatient workload totaled 678,216 visits in FY 2003 and 727,545 visits in FY 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 FYs 2003, 2004, and 2005 (through December 10, 2005) and was done in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 12 activities:

Controlled Substances	Pressure Ulcer Clinical Practices
Emergency Preparedness	Procurement of Supplies
Environment of Care	QM Program
Government Purchase Card Program	Service Contracts
MCCF	Supply Inventory Management
Patient Waiting Times	Time and Attendance for Part-Time Physicians

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all health care system employees, and 316 employees responded. We also interviewed 30 patients during the review. The survey results were shared with health care system managers.

We also presented four fraud and integrity awareness training sessions. A total of 357 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 Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Organizational Strength

Managers Implemented a Comprehensive Patient Safety Program. Health care system managers worked diligently to create a culture of safety in order to reduce unsafe conditions or unsafe actions that could harm patients. In FY 2004, they conducted 11 quarterly aggregate root cause analysis (RCA) reviews. They chartered 23 additional RCA teams to review specific adverse events and close calls. RCA team findings were then incorporated into the patient safety program. In addition, the health care system:

- Created a patient safety Web page.
- Published a patient safety newsletter.
- Developed and provided patient safety training throughout the health care system.
- Incorporated safety education in its resident training programs.
- Recognized safety champions[1] in patient care areas.

As a result, the health care system achieved its goals on 95 percent of its safety performance measures.

Opportunities for Improvement

Service Contracts – Preaward Audits Needed To Be Requested

Condition Needing Improvement. The health care system needed to request preaward audits of service contracts when required.

To evaluate contracting activities, we reviewed 14 noncompetitive and 6 competitive service contracts valued at about $23.9 million. Our review showed that contracting officers (COs) had appropriate warrant authorities, contract files were generally well organized, all required legal and technical reviews were done, and COs and contracting officers' technical representatives had received appropriate acquisition training. However, we identified one issue requiring management attention.

VHA policy requires that all noncompetitive contracts with affiliated medical schools valued at $500,000 or more be sent to the OIG for preaward audits. The primary purpose of a preaward audit is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. Our review included three contracts with a total value of about $10.1 million that required preaward audits. However, none of the

[1] A safety champion is an individual who has been recognized by the health care system as a vocal proponent and advocate of patient safety goals and practices.

required audits were requested by the health care system. This occurred because contracting managers incorrectly thought that the VA Office of Acquisition and Materiel Management would automatically request any required preaward audits as part of its legal and technical reviews of the health care system's contracts. We estimated that preaward audits would have resulted in cost savings of $1,317,165.[2]

Recommended Improvement Action 1. We recommended the VISN Director ensure the Health Care System Director takes action to request preaward audits when required.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that preaward audits will be requested when required. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened and Stock Levels Needed To Be Reduced

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

VHA policy establishes a 30-day supply goal and requires that medical facilities use the automated Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, the health care system's supply inventory included 4,630 line items valued at about $2.4 million.

We inventoried 61 line items to assess the accuracy of inventory records. In addition, we analyzed GIP and PIP data for all 4,630 line items in the supply inventory to determine whether the stock levels met the 30-day supply goal.

Inaccurate Inventory Records. To assess the accuracy of GIP and PIP data, we inventoried 33 medical, 18 engineering, and 10 prosthetics line items with a combined recorded value of $123,373. The stock levels recorded in GIP and PIP were inaccurate for 37 of the 61 (61 percent) line items, with 20 shortages valued at $44,961 and 17 overages valued at $9,979. The inaccurate inventory records occurred primarily because health care system personnel did not promptly record receipts and distributions of supplies. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. GIP and PIP data indicated that stock levels on hand were higher than needed. The stock levels for 2,610 of the 4,630 (56 percent) line items exceeded the 30-

[2] The OIG has determined that preaward audits have resulted in potential average savings of 21 percent of the total value of proposed contract prices. The OIG has also determined that 62 percent of the potential cost savings has been sustained during contract negotiations. Applying these percentages to the total estimated value of the contracts ($10,116,478 x 21 percent x 62 percent) resulted in estimated cost savings of $1,317,165.

day level. The total recorded value of supplies in excess of the 30-day level was $849,124.

Recommended Improvement Action 2. We recommended the VISN Director ensure the Health Care System Director takes action to: (a) reconcile differences and correct inventory records as appropriate, (b) record receipts and distributions promptly, and (c) reduce stock levels to meet the 30-day supply goal.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that a comprehensive inventory will be completed by April 22, 2005, and the results will be used to correct inventory records. The health care system will provide refresher training emphasizing the importance of recording receipts and distributions promptly. Also, a review of stock levels and usage rates will be completed, and the results will be used to reduce stock levels as appropriate. 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 health care system could increase MCCF collections by improving documentation of medical care and ensuring that MCCF personnel identify all billable VA and fee-basis care.

Under the MCCF program, VA is authorized to recover from insurance carriers the cost of treating insured veterans. In FY 2003, the health care system collected $14.5 million, which was 75 percent of its collection goal of $19.3 million. In FY 2004, the health care system collected $15.4 million, which was 91 percent of its collection goal of $17 million.

Care Not Properly Documented. Medical care providers needed to improve the documentation of care. The "Reasons Not Billable Report" lists episodes of care that MCCF personnel could not bill because, among other reasons, medical care providers did not adequately document the care in veterans' medical records. We reviewed 45 potentially billable episodes of care totaling $21,900 listed on the report for the 6-month period ending September 30, 2004. We identified 29 episodes of care with 30 missed billing opportunities totaling $15,537 that MCCF personnel could have billed if medical record documentation had been complete.

Billable VA Care Not Identified. To determine whether MCCF personnel identified all billable VA care, we reviewed 40 episodes of care: 15 inpatient discharges that occurred during September 2004; 15 outpatient visits that occurred on September 15, 2004; and 10 potentially billable episodes of care listed on the "Unbilled Amounts Detailed Report" for

the 6-month period ending September 30, 2004. We identified 18 episodes of care with 41 missed billing opportunities totaling $94,972.

Fee-Basis Care Not Billed. The Fee-Basis Unit authorizes payments to non-VA medical care providers furnishing fee-basis care to veterans. After authorizing payments for fee-basis care furnished to veterans with insurance, the Fee-Basis Unit forwards appropriate documentation to MCCF personnel, who bill the insurance carriers.

To determine whether MCCF personnel properly billed insurance carriers for fee-basis care, we reviewed the records for 15 episodes of care furnished during the period May 5, 2003, to June 21, 2004. We identified 9 episodes of care with 109 missed billing opportunities totaling $50,799.

Potential Collections. We estimated that additional bills totaling $161,308 ($15,537 + $94,972 + $50,799) could have been issued for the missed billing opportunities we identified. Based on the health care system's historical collection rate of 39.7 percent, MCCF personnel could have increased collections by $64,039 ($161,308 x 39.7 percent). As a result of our review, MCCF personnel issued 20 bills during our visit, and they were working to issue additional bills for the missed billing opportunities we identified.

Recommended Improvement Action 3. We recommended the VISN Director require the Health Care System Director to ensure that: (a) medical care providers adequately document the care provided, (b) all billable VA care is identified and billed, and (c) all billable fee-basis care is identified and billed.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that Coding, Decision Support Service, and Compliance Office personnel are working directly with medical care providers to ensure that the documentation of care is adequate. Procedures have been established to ensure that all billable VA care is identified and billed. The health care system has hired two additional personnel to assist in identifying, coding, and billing fee-basis care. In addition, program controls have been established to monitor the billing and collection of fee-basis care. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Condition Needing Improvement. The health care system needed to strengthen controls over timekeeping for part-time physicians. All of the 112 part-time physicians had designated at least 25 percent of their work hours as core hours in accordance with VHA policy. In addition, all of these physicians had signed agreements describing VA's expectations and the physicians' responsibilities. However, we identified four issues that required management attention.

Duty Not Performed During Core Hours. VHA policy allows part-time physicians to work adjustable tours of duty when they have patient care, research, or educational responsibilities that make adherence to a regularly scheduled tour of duty difficult. The adjustable tours of duty are made up of core and non-core hours. Core hours are the days and times in a biweekly pay period when part-time physicians must be performing VA duties unless granted leave or excused absences. Non-core hours are scheduled hours that may be adjusted at the request of part-time physicians provided the adjustments are consistent with VA patient care requirements.

To verify that part-time physicians were performing VA work during scheduled core hours, we conducted a roll call of 20 part-time physicians on December 6–7, 2004. We found one part-time physician who was attending a meeting at the university where he teaches instead of performing VA duties. As a result of our review, the Chief of Staff counseled the part-time physician and required him to submit a leave slip for the core hours he missed.

Time and Attendance Records Not Properly Prepared. VHA policy states that part-time physicians will record their hours of duty and leave each week on subsidiary time sheets and sign the time sheets. We interviewed 3 of 24 timekeepers who were responsible for the part-time physicians' time and attendance records. Two of the timekeepers, who were responsible for the records of 12 part-time physicians, inappropriately recorded the hours worked on the subsidiary time sheets for 8 of these physicians before giving the time sheets to the physicians for signature.

Timekeeper Desk Audits Not Performed. VA policy requires semiannual desk audits of all timekeepers. Health care system policy requires payroll personnel in Fiscal Service to conduct these desk audits. We reviewed all desk audit reports completed in FYs 2003 and 2004 for the 24 timekeepers responsible for maintaining the time and attendance records for part-time physicians. Our review showed that 10 of 73 (14 percent) required desk audits were not done. (Not all of the 24 timekeepers were serving as timekeepers for the entire 2-year period.)

Timekeeper Training Not Completed. VA policy requires that all timekeepers receive annual refresher training. Our review of timekeepers' training records showed that 2 of the 24 timekeepers did not receive refresher training in 2003. Similarly, as of December 10, 2004, 3 of the 24 timekeepers had not received refresher training in 2004.

Recommended Improvement Action 4. We recommended the VISN Director ensure the Health Care System Director takes action to ensure that: (a) part-time physicians perform VA duties during scheduled core hours of duty unless granted leave or excused absences, (b) part-time physicians record their hours worked on subsidiary time sheets, (c) Fiscal Service personnel perform all required semiannual timekeeper desk audits, and (d) all timekeepers receive annual refresher training.

The VISN and Health Care System Directors agreed with the finding and recommendations and reported that the Compliance Office is verifying that part-time physicians are performing VA duties during scheduled core hours on a daily basis. Part-time physicians are now recording their hours worked on subsidiary time sheets. The health care system is requiring quarterly timekeeper desk audits, and it will use a suspense file to ensure that all required audits are performed. In addition, the health care system has established procedures to ensure that all timekeepers receive annual refresher training. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 17 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2005

From: Director, Veterans Integrated Service Network (10N17)

Subject: **South Texas Veterans Health Care System, San Antonio, Texas**

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

1. Network 17 appreciates the OIG's review and recommendations concerning the South Texas Veterans Health Care System. Each action plan has been designed to completely address all issues identified within the recommendations. The VISN office is taking both the recommendations and the corrective actions very seriously. We will continue to monitor and ensure all recommendations are completely satisfied by the Target Completion Dates.

(original signed by:)

Thomas J. Stranova

Network Director

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2005

From: Director, South Texas Veterans Health Care System

Subject: **South Texas Veterans Health Care System San Antonio, Texas**

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

1. This is to acknowledge receipt and thorough review of the findings and recommendations of the Office of the Inspector General Combined Assessment Program Review conducted December 6-10, 2004. The South Texas Veterans Health Care System concurs with the IG findings and appreciates the opportunity to review the draft report.

2. We want to thank the team members for the comprehensive review and the opportunity to further improve the quality care we provide for our veterans.

(original signed by:)
Jose R. Coronado, FACHE

Health Care 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 Recommendations

Recommended Improvement Action 1. We recommend the VISN Director ensure the Health Care System Director takes action to request preaward audits when required.

Concur **Target Completion Date:** Completed

The STVHCS concurs with the recommendations of the OIG and will take action to request pre-award audits when required.

Recommended Improvement Action 2. We recommend the VISN Director ensure the Health Care System Director takes action to: (a) reconcile differences and correct inventory records as appropriate, (b) record receipts and distributions promptly, and (c) reduce stock levels to meet the 30-day supply goal.

Concur **Target Completion Date:** 4/22/05

STVHCS concurs with the recommendations of the OIG and will take action to (a) reconcile differences and correct inventory records as appropriate, (b) record receipts and distributions promptly, and (c) reduce stock levels to meet the 30-day supply goal. We will conduct a wall-to-wall inventory, and use the results to correct inventory records. We will also provide refresher training emphasizing the importance of recording receipts and distribution promptly. A review of stock levels and usage rates will be completed and used to reduce stock levels, as appropriate. Recommendation (c) will be more achievable once we go on line with the recently awarded Medical/Surgical Prime Vendor.

Recommended Improvement Action 3. We recommend the VISN Director require the Health Care System Director to ensure that: (a) medical care providers adequately document the care provided, (b) all billable VA care is identified and billed, and (c) all billable fee-basis care is identified and billed.

Concur **Target Completion Date:** 6/30/05

a. Since the CAP review in December, when billable cases are identified, Coding, DSS and Compliance work directly with the medical care providers by assisting them in documenting the care provided. Since December 2004, we have improved documentation of billable cases by 90%.

b. To address this recommendation, BO/MAS is actively participating on the VISN 17 Revenue Improvement Team to identify all potential and missed billing opportunities and to identify best practices in billing. To ensure all billable encounters identified in VistA are billed, at the end of each month, the lead biller will run the Unbilled Amounts Report for two years, and distribute it to the billers. Billing staff will review claims from the Unbilled Amounts Report and determine the status of each claim and report it to the lead biller. The lead biller will ensure needed follow up has been accomplished. BO/MAS is working closely with the ACOS/Education to improve documentation for all resident supervised care. The target completion of these initiatives is June 30, 2005.

c. BO/MAS has established and filled positions for a fee coder and a fee biller to aid in a process that has been put into place to identify all billable fee-basis care, obtain necessary documentation, and to code and bill for the care. Revenue Coordinator will monitor collection for fee-basis care on a monthly basis and report through the Business Office to the Associate Director. The target completion of this initiative is May 31, 2005.

Recommended Improvement Action 4. We recommend the VISN Director ensure the Health Care System Director takes action to ensure that: (a) part-time physicians perform VA duties during scheduled core hours of duty unless granted leave or excused absences, (b) part-time physicians record their hours worked on subsidiary time sheets, (c) Fiscal Service personnel perform all required semiannual timekeeper desk audits, and (d) all timekeepers receive annual refresher training.

Concur **Target Completion Date:** 5/1/05

a. We now have a full-time member of the compliance office staff making rounds daily to nursing units, laboratories, offices and all areas where physicians are located to verify compliance with core-hour schedules. We had one (1) part-time physician during the CAP audit who was delayed at the Medical School because his scheduled lecture ran late. Upon contacting him during the audit, he indicated that his lecture had infringed on his core time and he would record his time (annual leave) upon his return. In the past 12 months, we have had no violations of documentation requirements of core time for part-time physicians. We believe this fully meets the regulatory requirements for timekeeping.

b. All part time physicians now record their hours on subsidiary time sheets and certify "correct". This practice is in compliance with our hospital policy and the pertinent directives. New policy changes currently being implemented nationally will require practitioners to enter directly onto electronic subsidiary time sheets. We expect this electronic timekeeping software to be available in April 2005.

c. Our payroll policy now requires that timekeeper audits be accomplished quarterly. A suspense file system will be put in place to insure/verify these audits are timely accomplished. Timekeepers that post part-time physicians will be audited at least quarterly. Individuals no longer performing timekeeper duties have been reassigned.

d. To ensure that appropriate and timely annual refresher training is accomplished, a web based timekeeper refresher training program in now available on-line. ACOS/Education runs a quarterly report reflecting completion of this training; this report is provided to the Payroll Section for monitoring and follow up actions. Each Payroll Technician monitors this report to insure all timekeepers within their T&L area of responsibility timely complete this refresher training. The Payroll Technician performs follow up for any training compliance deficiencies with the timekeeper and the appropriate timekeeper supervisor.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds
1	Preaward audits would result in reduced contract prices.	$1,317,165
2	Reducing stock levels would make funds available for other uses.	849,124
3	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	64,039
	Total	$2,230,328

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Jehri Lawson, CAP Review Coordinator, Dallas Audit Operations Division (214) 253-3304
Acknowledgments	William Bailey Linda DeLong Clenes Duhon Glen Gowans Michael E. Guier Ed Hendrickson John Houston Joel Snyderman Virginia Solana Sally Stevens John Weber Marilyn Walls

Appendix E

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