



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Louisville, Kentucky

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 October 25–29, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Louisville, KY. 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 139 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 9.

Results of Review

This CAP review covered 16 areas. There were no concerns identified in five areas:

- Bulk Oxygen Utility System
- Information Technology Purchases
- Information Technology Security
- Supply Processing and Distribution
- Part-Time Physician Time and Attendance

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

- The medical center implemented a fully integrated strategic management system that encompassed strategic planning, data management and analysis, and performance improvement.

Eleven areas needed management attention. To improve operations, the following recommendations were made:

- Reduce excess supply inventories and strengthen inventory management controls.
- Increase Medical Care Collections Fund (MCCF) billings by strengthening procedures to prevent missed billing opportunities.
- Correct safety and environmental deficiencies.
- Report suspected controlled substances discrepancies to the OIG, make sure inventory records are available for unannounced inspections, and perform a complete inventory when a new Pharmacy Service Chief is appointed.

- Implement the use of InterQual® criteria for determining the appropriateness of patient admission and length of stay and focus performance improvement initiatives on alternatives to restraint and seclusion use.
- Install lockable steel cabinets in the vault or purchase a new Type II vault for Pharmacy Service.
- Improve physical security of the Agent Cashier area.
- Document follow-up collection actions on accounts receivable.
- Include all required documents in contract files.
- Perform quarterly audits of all cardholder accounts and make sure Government purchase card transactions are timely reconciled and approved.
- Ensure that surgical operation reports specify the roles of the attending surgeons and document the presence and involvement of the attending surgeons.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Mark Collins, Audit Manager, Chicago Audit Operations Division.

VISN 9 and Medical Center Director Comments

The VISN 9 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. The VISN 9 Director agreed with qualifications to recommendation 1a to reduce supply levels to a 30-day supply and eliminate excess and inactive line items. In our opinion, Veterans Health Administration (VHA) guidance is clear on this subject, and we believe that stock levels should be reduced to make funds available for other uses. The process the medical center has in place meets the intent of the recommendation. (See Appendixes A and B, pages 16-30, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care facility that offers a full range of services and operates five community-based outpatient clinics: three in the greater Louisville area, one at Fort Knox, KY, and one in New Albany, IN. The medical center's primary service area includes 28 counties in north central Kentucky and 12 counties in southern Indiana. Certain fiscal and contracting functions are centralized at the Murfreesboro VA Medical Center.

Programs. The medical center has 104-beds and provides medical, surgical, and psychiatric services. It also offers special programs such as physical medicine, rehabilitation, oncology, geriatrics and extended care, and women's health care services.

Affiliations and Research. The medical center has 31 affiliation agreements with local institutions including the University of Louisville School of Medicine and School of Nursing. It supports 93 residents and fellows and provides rotational training to approximately 350 university residents, interns, and students.

During fiscal year (FY) 2004, the medical center's research program had 134 projects. The total research funding for FY 2004 from VA was \$2 million.

Resources. The medical center's FY 2003 operating budget was \$146 million and the FY 2004 operating budget was \$157 million. FY 2004 staffing was 1,066 full-time equivalent employees (FTE), including 90 physician FTE and 261 nursing FTE.

Workload. The medical center treated 37,909 unique patients in FY 2003 and 38,874 unique patients in FY 2004. Inpatient workload totaled 6,248 discharges in FY 2004. The FY 2004 average daily bed census was 88 for acute care. The outpatient workload totaled 372,419 visits for FY 2003 and 423,179 visits for 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 patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information 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 16 activities:

Accounts Receivable	Medical Care Collections Fund
Agent Cashier	Medical Record Documentation
Bulk Oxygen Utility System	Part-Time Physician Time and Attendance
Contracting	Pharmacy Cache
Controlled Substances Accountability	Quality Management Program
Environment of Care	Supply Processing and Distribution
Government Purchase Card Program	Supply Inventory Management
Information Technology Purchases	
Information Technology Security	

The review covered medical center operations for FYs 2003 and 2004 and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees who had Internet access, and 244 employees responded. We also interviewed 30 patients during the review. The results of the employee and patient surveys were discussed with medical center management.

We conducted 3 fraud and integrity awareness briefings that were attended by 139 medical center 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.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–15). For these activities, 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 the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Organizational Strength

The Medical Center Implemented a Fully Integrated Strategic Management System.

We reviewed the business plans for the medical center's strategic management system and found that a key component of this system was the implementation of a business planning process that incorporated strategic and financial planning. Service chiefs and product line managers had developed fully integrated operating business plans to forecast workload and resource requirements and to identify equipment, space, and construction needs to accomplish organizational goals and improve patient care. Opportunities for improvement and major performance gaps were identified and addressed through business planning and were tracked using the balanced scorecard approach.¹ Managers used balanced scorecards at the organizational and service/product line levels to track performance improvement and the implementation and outcomes of strategic and business plan initiatives, as well as VHA/VISN performance measurement requirements. By linking resource allocations to strategic planning priorities and tracking QM accomplishments with a balanced scorecard, senior managers were able to make objective business decisions. VISN 9 managers have recognized the benefits of this approach and have suggested that other medical centers in the VISN adopt this methodology.

¹ The balanced scorecard is a management system that enables organizations to clarify their vision and strategy and translate them into action. It provides feedback around both the internal business processes and external outcomes in order to continuously improve strategic performance and results.

Opportunities for Improvement

Supply Inventory Management — Excess Inventories Needed To Be Reduced and Inventory Controls Improved

Conditions Needing Improvement. In FY 2004, the medical center spent approximately \$11 million on medical, prosthetic, and engineering supplies. VHA established goals for reducing supply inventories to 30-day levels and for using Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage these inventories. Medical center staff used GIP to manage medical and engineering supplies and PIP to manage prosthetics supplies. However, to improve inventory management they needed to correct six inventory management deficiencies.

Excess Inventory. Medical center staff needed to monitor supply usage rates and adjust stock levels to a 30-day supply. To evaluate supply usage rates, we reviewed judgment samples of 10 items each from medical and prosthetic line items.

- Seven of 10 sampled medical supply items had stock levels ranging from 96 days to over 2 years. The value of the excess stock was \$2,368.
- The 10 prosthetics supply line items had excess stock levels ranging from 231 days to 2 years. The value of this excess stock was \$20,102.

In addition, as of October 25, 2004, the GIP “Days of Stock On Hand” reports showed that Radiology Service, Cardiac Catheterization Laboratory, and Supply Processing and Distribution had 688 line items with excess stock valued at \$96,000, including 154 inactive line items with a value of \$8,281.

Inaccurate Inventories. Information in GIP and PIP did not accurately reflect the supply levels for engineering and prosthetics supplies. These inaccuracies occurred because bar coding was not implemented, clerks were not adequately trained, and annual physical inventories were not conducted. Inaccuracies in inventory data can lead to unexpected shortages of needed supplies or premature orders for their replenishment. As of October 25, 2004:

- For 10 Engineering Service line items, GIP showed that there were 538 units with a value of \$6,179. Our physical inventory found only 482 units on hand, resulting in an overstatement of 56 units (12 percent) with a value of \$2,055.
- For 10 Prosthetics Service line items, PIP showed that there were 194 units with a value of \$23,094. Our physical inventory found only 206 units on hand, resulting in an understatement of 12 units (6 percent) with a value of \$1,230.

Bar Coding Not Implemented. Prosthetics Service staff did not use bar coding technology to identify and track prosthetic supplies. According to the Prosthetics Service Chief, the bar coding equipment had been received and would be fully operational by the end of calendar year 2004.

Inadequate Training. Receipts of supplies were not posted timely and accurately into PIP because the two purchasing clerks lacked adequate training. One purchasing clerk had not received any training on PIP in over a year, and the other had received no training.

Annual Physical Inventories Not Conducted. VHA policy requires a complete annual inventory of all supplies. Engineering Service staff had not conducted annual physical inventories of supplies for 3 years. Distribution of supplies were written on a requisition list and recorded in the inventory weekly. Once a month staff took a partial physical count and manually entered the count into GIP. According to the Logistics Manager, the Engineering Service “Days of Stock On Hand” report did not reflect all inventory and GIP was understated.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) reduce supply levels to a 30-day supply and eliminate excess and inactive line items, (b) ensure that GIP and PIP information is accurate, (c) implement bar coding for Prosthetics Service supplies, (d) train Prosthetics Service clerks on use of PIP, and (e) conduct annual physical inventories in Engineering Service.

The VISN Director agreed with the findings and recommendations for 1b, c, d, and e. The Acquisition and Materiel Management Service Line (A&MMSL) has established mandatory training on GIP for all users. They are using the GIP package to track and improve inventory accuracy. Engineering Service will conduct weekly inventory distribution postings for stock pulled. The employee who orders and posts inventory has received additional PIP training. Using bar coding, an employee will verify all PIP inventory points weekly. Prosthetics Service has received bar coding equipment and training for the staff will be conducted. The Prosthetics Service staff has received PIP training. Employee actions will be reviewed weekly for completeness and timeliness. An annual inventory for Engineering Service will be accomplished by inventorying 10 percent of the line items each month. At the end of 12 months, all line items will have been physically counted. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

However, the VISN Director agreed with qualifications to recommendation 1a. While the A&MMSL has established a process for reviewing excess and inactive items monthly, the Director stated that many of the items we identified as excessive or inactive are actually “just-in-case” or infrequent use items that must be maintained. He also stated that the “Days of Stock on Hand” report we used did not take into account the total days of stock on hand for the entire inventory as stated in VHA Handbook 1761.2, VHA

Inventory Management. He contended that Paragraph 5.b. of the VHA Inventory Management Handbook requires facilities to keep total inventory averages at 30 days, not individual line items.

However, the VHA Inventory Management Handbook does not use the term “just-in-case.” It does refer to an emergency stock level and states that this represents the smallest amount of an item to be maintained in the inventory point. In his response, the VISN Director gave the Cardiology Inventory Account as an example of an inventory that does not routinely average 30 days of stock on hand because of the variety of specialty items needed for procedures that may be infrequently performed. However, the “Days of Stock Greater Than 30 Days” report from October 1, 2003, to October 25, 2004, showed that Cardiology had 182 line items, of which 87 (48 percent) items exceeded 30 days stock on hand. The total medical items for Cardiology, SPD, and Radiology were 2,251 of which 688 (31 percent) items were in excess of 30 days. In our opinion, these were very high emergency stock levels.

Paragraph 5.b. of the handbook also states that “Stock levels are established to maintain constant availability of items; however an average of not more than 30 days stock on hand is required. Levels for on-demand items must be kept at a minimum to avoid overstocking.” We interpret this to mean an average of individual line items maintained in GIP. However, even if the passage is referring to the whole inventory account, it is sound business practice to reduce individual items to 30-day levels regardless of the entire stock’s average, as long as patient care is not compromised, in order to make funds available for other uses. The Director stated that A&MMSL has an established process for reviewing excess and inactive stock. This meets the intent of the recommendation, and we will follow up on planned actions until they are completed.

Medical Care Collections Fund — Procedures for Billing Needed To Be Strengthened

Condition Needing Improvement. MCCF staff verified patient insurance, billed appropriately and timely, and ensured collection efforts were prompt. For third party receivables, the medical center exceeded VHA’s collection goals for the last 3 fiscal years; however, there were missed billing opportunities.

We reviewed the “Reasons Not Billable” report for the period February 2004 through August 2004. It listed 864 potential billable cases totaling \$309,991 that were not billed because of insufficient documentation, no documentation, or a non-billable provider.

We reviewed a judgment sample of 45 potential billable cases totaling \$38,071 and found that only 5 had been correctly classified as not billable. The other 40 cases represented missed billing opportunities valued at \$37,334. Based on the medical center’s FY 2004 collection rate of 40 percent, MCCF staff could have increased collections by \$14,934 (\$37,334 x 40 %). According to the Health Information Management Systems Chief, this

problem occurred because procedures for follow-up on episodes of care with missing documentation were inadequate. MCCF staff will send bills for these missed opportunities.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) bill third parties for the missed billing opportunities identified and (b) strengthen review procedures to prevent missed billing opportunities.

The VISN Director agreed with the findings and recommendations and reported that Health Information Management Systems staff are reviewing all encounters not billed because of missing or incomplete medical documentation. The encounters will be followed up until the documentation is received. Medical center management monitors all cases from the “Reasons Not Billable” report that have missing or insufficient documentation. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Environment of Care — Safety and Environmental Deficiencies Needed To Be Corrected

Conditions Needing Improvement. Medical center managers needed to ensure that medications were secured, emergency crash carts were checked according to medical center policy, and patient safety and privacy concerns were corrected in the inpatient mental health unit. We conducted environment of care inspections on six inpatient units and five outpatient areas.

Medication Security. On two inpatient units, medication carts were unlocked and unattended. In the Emergency Room (ER), a medication was stored in an unlocked treatment cart. Medications must be secured to ensure patient safety and to prevent diversion.

Emergency Crash Cart Checks. Medical center policy states that defibrillators located in areas where patients are housed overnight will be checked every 8 hours. Checks will be done within the first 2 hours of the 8-hour shift or the opening of the patient care area. Crash cart checks include defibrillator checks and are recorded on a crash cart log. The October 2004 emergency crash cart logs showed that checks were not completed on three inpatient units and in the ER. Checks are necessary to ensure that all emergency equipment functions properly and necessary emergency supplies are available.

Patient Safety and Privacy Concerns. Inpatient mental health units must be designed to ensure patient safety and protect patients who may intend to harm themselves. Two showerheads in a women’s shower room were not constructed to break away with weight (shown in photograph at right).



Additionally, this room was unlocked and accessible to patients. Seven inpatient mental health unit rooms facing the interior part of the medical center did not have blinds, compromising patient privacy. During the CAP review, managers ensured that the showerheads were replaced with flush-mount fixtures, and a planned construction project included installation of new windows with interior blinds in the inpatient mental health unit.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) medication carts are secure, (b) emergency crash carts are checked according to medical center policy, and (c) patient safety and privacy concerns are corrected in the inpatient mental health unit.

The VISN Director agreed with the findings and recommendations and reported that the Nursing Supervisor will randomly check unattended medication carts to ensure they are locked on all tours. Nursing staff has been re-educated in the requirements for checking defibrillators. Showerheads were replaced, and interior door windows and exterior windows will be replaced with units that have blinds in the inpatient mental health unit. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Controlled Substance Accountability – Controls Needed To Be Strengthened

Condition Needing Improvement. VHA policy requires Pharmacy Service staff to maintain accountability of all controlled substances. Our review of pharmacy controls, inspection procedures, and security identified three deficiencies that needed improvements.

Reported Discrepancies. VHA and medical center policies require management to report suspected thefts, diversions, or other suspicious losses of controlled substances to VA Police and the OIG. From September 2003 to August 2004, VA Police investigated 20 reported incidents of missing controlled substances. There was evidence that 19 of the 20 reports were forwarded to the OIG for further investigation. However, the one unreported case showed six expired codeine tablets were not accounted for in the controlled substances inspection report dated June 2004. There was no evidence of destruction, and the incident was not reported to the OIG. A VA Police investigation showed that the tablets had been returned to the inpatient pharmacist, who had left them on a desk unattended.

Controlled Substances Inventory Records. Controlled substances inspectors use the “Controlled Substances Administration Records” to conduct inspections. During three unannounced inspections performed in May, June, and July 2004 the inspectors could not verify the inventory on three wards (one ward each month) because the “Controlled Substances Administration Records” were missing or incomplete. Inventory records

identified the quantity of controlled substances on hand, but the records were not returned to the pharmacy from the wards. Unannounced inspections cannot be properly completed if these records are unavailable or incomplete. The Control Substances Coordinator stated that local policy has been established to comply with VA policy and to ensure the inventory records are complete and available for the inspections.

Complete Turnover of Inventory. VHA policy requires that a complete inventory be conducted when there is a permanent change of the medical facility's Pharmacy Service Chief. The former Pharmacy Service Chief, the new Pharmacy Service Chief, and the medical facility's inspecting officials are to sign the record of the inventory. The new Pharmacy Service Chief took over in July 2003, but no inventory was conducted.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) comply with VHA policy to report missing controlled substances to the OIG, (b) ensure that controlled substances inventory records are complete and available for monthly unannounced inspections, and (c) ensure a complete inventory is conducted upon the permanent change of the Pharmacy Service Chief to comply with VHA policy.

The VISN Director agreed with the findings and recommendations and reported that when Pharmacy Service discovers the loss or apparent loss of a controlled substance, the Pharmacy Service Chief will contact the OIG by email at the same time the VA Police are informed. Changes to local policy were implemented requiring all inventory records to be turned into pharmacy within 48 hours after the last entry has been made on the inventory sheets and reviewed by the manager. The Pharmacy Service Chief is now aware that an inventory must be conducted when he leaves his position, and an addendum to the Functional Statement for the Pharmacy Service Chief has been made requiring a complete controlled substances inventory when a new chief is appointed. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Quality Management Program — Aspects of the Program Needed Strengthening

Condition Needing Improvement. The medical center's QM program was effective. QM activities were fully integrated into the strategic management and business planning processes of the medical center. Senior managers demonstrated their support through active participation on committees and root cause analysis teams and by providing the necessary resources to accomplish initiatives. The QM Manager and staff demonstrated a coordinated approach to QM activities. However, some aspects needed strengthening.

Utilization Management. Utilization management is a process in which resource-intensive occurrences such as admissions, readmissions, and continued stays are reviewed against criteria. VISN 9 policy stipulates that the medical center establish a utilization

management program and use InterQual® criteria² to make decisions about the medical necessity of admission to, continued stay at, and discharge from hospital levels of care. To determine the appropriateness of admission and duration of hospitalization, nurses conducting utilization management reviews used an estimated length of stay based on admitting diagnosis. Using this method, the level of care a patient received and the length of time the patient remained in the hospital, possibly at a more acute and expensive level of care, was not closely monitored and modified as the patient's changing condition warranted. Senior managers stated that they planned to use the InterQual® criteria for FY 2005 reviews.

Patient Restraint and Seclusion. Patient restraint and seclusion usage rates were higher than facility-established criteria. During the 12 months prior to our CAP review, QM reviews of patient restraint and seclusion focused on documentation of the use of restraint and seclusion. This documentation includes physicians' orders to initiate or discontinue a restraint or seclusion and nurses' notes monitoring patient care during restraint or seclusion. To correct identified problems with untimely and incomplete documentation, managers developed electronic templates for physician orders and nurse notes. The templates were implemented during the 2 months before the CAP review. Preliminary reviews indicated that documentation timeliness and completeness had improved. However, restraint and seclusion usage rates had not improved. In order to reduce these rates, managers needed to focus QM's attention on preventive strategies and alternatives to the use of restraint and seclusion.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the use of InterQual® criteria is implemented to determine appropriateness of patient admission and length of stay and (b) QM initiatives focus on preventive strategies and alternatives to the use of restraint and seclusion.

The VISN Director agreed with the findings and recommendations and reported that the medical center is using InterQual criteria for all preadmission reviews and plans to implement criteria for continued stay review by May 2005 and reorganize utilization review under the Strategic Management Service. Preventive actions and alternatives to restraint and seclusion are now being tracked and trended and will be evaluated monthly. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

² InterQual® criteria are a set of measurable, clinical indicators, as well as diagnostic and therapeutic services, that reflect a patient's need for hospitalization. Rather than being based on diagnosis, they consider the level of illness of the patient and the services required; thus, they serve as the criteria for acute hospital care, regardless of location or size of the hospital. InterQual® criteria are research-based, objective benchmarks for screening clinically appropriate decisions.

Pharmacy Cache — Physical Security Needed To Be Improved

Condition Needing Improvement. VA's Pharmaceutical Cache Program was established to provide emergency medical support to the public in the event of a natural disaster, emergency, or terrorist attack. The medical center's cache program was established in accordance with VHA policy. Pharmacy cache controlled substances were included in monthly controlled substances inspections, and expiration dates were monitored. However, physical security over the cache needed improvement.

VA policy requires that drugs classified as controlled substances be stored in General Services Administration (GSA) approved safes or vaults. GSA classifies vaults as either Type I, which is used by the medical center, or Type II. Type I vaults are not as permanent or as strong and require lockable steel cabinets in the vault to compensate for the reduced security. The medical center's Type I vault did not have lockable steel cabinets.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director takes action to install lockable steel cabinets in the vault or purchase a new Type II vault.

The VISN Director agreed with the finding and recommendation and reported that lockable steel cabinets meeting Type I security requirements have been ordered. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Agent Cashier — Physical Security Needed To Be Improved

Condition Needing Improvement. The amount of the Agent Cashier's cash advance was appropriate and staff properly conducted unannounced audits every 90 days. However, physical security of the Agent Cashier office needed to be improved to comply with VA policy and provide adequate protection for the Agent Cashier's activities. The Agent Cashier cage had a steel-plated door, not the required steel or solid wood door. The pass-through window's opening could allow for unauthorized access because it was large enough for a person to reach through the opening. In addition, there was no panic button to activate in the event of an emergency.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to correct the Agent Cashier security deficiencies.

The VISN Director agreed with the finding and recommendation and reported that the medical center will replace the existing door with a steel door and install a peephole; install new glass in the pass-through window frame to eliminate reach-in; install duress alarms at both desks; and install a motion detector and relocate the audible alarm. The

implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Accounts Receivable — Documentation of Follow-Up Collection Actions Needed To Be Improved

Condition Needing Improvement. Fiscal Service staff ensured that accounts receivable were recorded timely, were reconciled with individual accounts monthly, and were reviewed periodically. However, documentation of follow-up collection actions needed improvement.

VA policy requires that accounts receivable be aggressively and promptly pursued for collection and that follow-up collection actions be documented in accounting records. As of September 30, 2004, the medical center had 3,101 accounts receivable worth \$950,593. This included 1,901 receivables (61 percent) worth \$108,964 that were more than 90 days old and considered delinquent. We reviewed a judgment sample of 20 of these receivables worth \$6,619 and found that accounting records did not show aggressive or timely follow-up collection actions for 14 accounts (total value = \$4,533) beyond automatically generated routine demand letters and referrals to the Treasury Offset Program.

According to the Fiscal Service Chief, they had not replaced an accounting technician responsible for follow-up actions after he left the medical center 3 years ago. Another accounting technician was given these responsibilities in addition to other duties, but did not have sufficient time to document all follow-up actions in the accounting records.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director requires Fiscal Service staff to aggressively and promptly follow up on delinquent accounts receivable and document these collection efforts.

The VISN Director agreed with the finding and recommendation and reported that the aged receivable report will be reviewed monthly for follow-up. All “Explanation of Benefits” correspondence and telephone calls will be documented and diaried for follow-up. A statistical review will be conducted every 6 months. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Contracting — Contract File Documentation Needed To Be Improved

Condition Needing Improvement. Sharing agreements between the medical center and the Department of Defense were administered effectively. The medical center contracting officer worked with contracting officers’ technical representatives to ensure that contractors provided the specified services. However, the contracting officer needed to improve contract file documentation.

The Federal Acquisition Regulation (FAR) requires that contracting officers document bids, conduct cost analyses for negotiated purchase contracts, evaluate contractor suitability and past performance, and prepare price negotiation memorandums (PNMs). The FAR also requires that contracting officers review contracts before renewal to ensure that contractors performed adequately and that costs continue to be reasonable.

We reviewed 10 service contracts valued at \$3.9 million and 4 sales agreements that sold \$179,500 in services during FY 2004. Files for all 10 contracts and 1 sales agreement did not contain all required documentation. For example:

- Nine of 10 contract files did not contain PNMs.
- One file for a radiology services contract valued at \$1,776,750 did not contain documentation showing whether the contractor was the sole bidder.
- A reconstructed file for a \$990,520 contract to obtain radiology services from an affiliate did not include Medical Service's request for radiology services, records of bidding, price reasonableness, justification for sole source award, and documentation of past performance and market conditions reviews used to decide whether to renew the contract.
- The file for a \$375,000 ambulance services contract did not contain documentation of a review of market conditions, the number of bidders, assessments of contractor performance, and market reviews before exercising options to renew the contract. The bidding document submitted by the contractor had no date stamp or any other evidence showing that VA received it before the bidding closing date.
- One sales agreement with the VA Regional Office Louisville lacked the Medical Center Director's certification that the agreement met VHA criteria.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director requires the contracting officer to include all required documents in the contract files.

The VISN Director agreed with the finding and recommendation and reported that a quality technical review process is being established to ensure that all required documents are in the contract files. Contract review reports will be filed in the contract files. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Government Purchase Card Program — Controls Needed To Be Strengthened

Condition Needing Improvement. Government purchase card officials adequately monitored purchase card transactions, and we found no instances of inappropriate purchases. However, purchase card officials needed to perform quarterly audits of all

cardholders, approve purchase card transactions, and improve the timeliness of reconciling purchase card transactions.

Quarterly Reviews. VA policy requires the purchase card coordinator and the billing officer to conduct a joint review of all cardholders' accounts each quarter. The billing officer audited a sample of one purchase from one account for each cardholder every quarter. He reviewed all cardholder accounts only once a year.

Purchase Card Transaction Reconciliations. VA policy requires every charge to be reconciled or disputed, as appropriate, before it is 30 days old. For the 3-month period of June 1 through August 31, 2004, a sample of eight reconciliations totaling \$2,510, showed that in two cases cardholders took 68 and 103 days to reconcile the charges. These purchases were not disputed by anyone and were final.

Purchase Card Transaction Approvals. VA policy requires that approving officials approve Government purchase card transactions within 14 days of cardholders' reconciliations. For 3,083 transactions totaling \$3,260,086 that occurred from June 1 through August 31, 2004, there were 107 (3 percent) unapproved transactions with a value of \$48,110. These transactions were final and reconciled, but unapproved. In addition, for 189 transactions with a value of \$127,087, approving officials exceeded the 14-day requirement by taking from 15 to 88 days to approve the transactions. Prompt approval of transactions ensures that they are appropriate and accurate.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) audit all cardholder accounts quarterly, (b) establish controls to ensure that Government purchase card transactions are timely reconciled, and (c) comply with VA timeliness standards for approving reconciled purchase card transactions.

The VISN Director agreed with the findings and recommendations and reported that with the filling of a vacant accountant position and the implementation of a certification checklist, Fiscal Service will monitor all cardholder accounts quarterly. Fiscal Service staff will send twice-weekly reports to all service chiefs showing reconciliations over 11 days old by cardholder and will inform all Prosthetics and Acquisition and Material Management (A&MM) users twice weekly of the status of all reconciliations. The Agency Organization Program Coordinator will notify approving officials twice weekly of items needing approval. The A&MM Chief will use a monthly spreadsheet to track individuals not in compliance. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Medical Record Documentation — Documentation of Surgical Procedures Needed To Be Improved

Condition Needing Improvement. As part of our review of part-time physician time and attendance, we reviewed operation reports for surgeries performed from July 1 to August 31, 2004, to determine whether part-time physicians participated in surgical procedures during their tours of duty.

Primary Surgeon. VHA policy requires that the operation report in a patient record contain the names of the primary surgeon, attending surgeon, and assistants. To comply with the policy, the Surgical Service Chief directed surgeons to follow a detailed template, which incorporates that information, when dictating operation reports. For 10 of the 25 sampled surgeries, operation reports did not identify the primary surgeon when the report listed more than 1 surgeon.

Role of Attending Surgeon. VHA policy also requires that the operation report document the presence and involvement of the attending surgeon for the procedure. For 9 of the 25 sampled surgeries, operation reports did not specify the role of the attending surgeon. Some surgeons did not follow the template when dictating the operation report, and some did not know that the role of the attending surgeon should be included.

Recommended Improvement Action 11. We recommended that the VISN Director ensure that the VAMC Director take action to ensure that: (a) operation reports specify the primary surgeon in each case and (b) operation reports document the presence and involvement of the attending surgeon in each case.

The VISN Director agreed with the findings and recommendations and reported that the dictation instructions will be modified to include primary surgeon, attending surgeon, and assistants; and will include a statement on the attending's involvement. The Medical Records Section will complete a 100 percent review of operative records and Surgical Service will complete a monthly 50-chart review of operation reports to ensure compliance with the documentation of the primary surgeon and the role of the attending surgeon. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

VISN 9 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 25, 2005

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the VA
Medical Center Louisville, Kentucky**

To: Director, Operational Support Division (53B)

Thru: Director, Management Review and Administration

1. Attached please find VAMC Louisville 's response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted October 25-29, 2004.
2. I concur with the Medical Center Director's comments and action plans.
3. If you have any questions or need additional information, please contact Staff Assistant to the Network Director at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date:

From: Acting Medical Center Director

Subject: VA Medical Center Louisville, Kentucky

To: Assistant Inspector General for Healthcare Inspection
(53B)

Thru: Director, Mid South Network, VISN 9, (10N9)

1. I wish to thank the OIGCAP Survey Team for their professional, comprehensive, fair survey October 25-29, 2004. I concur with the findings and recommendations. Most corrective actions are, in fact, either complete or near complete.

2. The Louisville VAMC staff is also very proud of the results of the patients surveyed by the OIG and overall ratings provided. Again, my thanks to the OIG Team for the comprehensive survey, their collective efforts and expertise in promoting continuous improvement in care to our veterans is greatly appreciated.

3. If you have any questions, please contact Emma Metcalf, Chief Strategic Management Service at (502) 287-5331.

(original signed by:)

Wanda Mims

Medical Center Director's Comments to Office of Inspector General's Report

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) reduce supply levels to a 30-day supply and eliminate excess and inactive line items.

Comments: Concur (with Qualifications) for GIP & PIP
Target Completion Date: See Below

We concur that there may be some items that could be reviewed for possible reduction of stock, however many of the items are "just-in-case" or infrequent use items that must be maintained, even though they impact the average days of stock on hand. The "Days of Stock On Hand" report utilized for the OIG review was queued to run with the parameter of showing only items with greater than 30 days supply and doesn't take into account the total days of stock on hand for the entire inventory as stated in VHA Handbook 1761.2, VHA Inventory Management.

Although there were specific line items identified in each of the referenced GIP accounts with quantity on hand that appears to be in excess of 30 days, the average stock level for SPD and Radiology routinely average 30 days stock on hand (12 turns), or less. In accordance with VHA Handbook 1761.2 Paragraph 5.b., it is the average that is required to be 30 days, not the individual line items. For the clinical areas, the just-in-case items that turn very slowly are offset by the items that turn very quickly, thereby enabling the inventory account to maintain an average of 12 turns, or 30 days stock on hand. The following average turn rates were taken directly from the Stock Status Report in each of these Inventory Accounts. This is the report that is submitted to the VHA Clinical Logistics Office monthly.

Month	SPD	Radiology
Sep 04	17.80	12.15
Oct 04	16.99	34.99
Nov 04	14.22	9.68
Dec 04	12.12	12.34
Jan 05	14.70	19.80
Feb 05	15.45	19.50

In addition, the items referred to as excess stock, valued at \$96,000 for Radiology Service, Cardiac Catheterization Laboratory, and Supply Processing and Distribution are reflecting a majority of the “just in case” items that must be kept on hand to assure we are able to meet all of our patient’s needs and are able to repair utility systems, real property and equipment on an emergency basis.

The Cardiology Inventory Account does not routinely average 30 days stock on hand because a wide variety of sizes must be stocked for these specialty items to assure the surgeon has whatever size he needs to complete any given procedure. Consequently, several months may pass when specific sizes are not needed, which affects the turn rates. We have attempted to secure these items through consignment, however the vendors are not willing. We will continue to review cardiology long supply and inactive items to assure that only those items required to care for the patient are maintained in stock.

Louisville A&MMSL has an established process for reviewing excess and inactive items at the monthly Commodity Standards Meeting. This process will continue to assure that truly inactive items are excessed in accordance with property regulations.

(b) ensure that GIP and PIP information is accurate.

Concur **Target Completion Date:** Complete

GIP Inventory Accuracy:

VISN 9 Acquisition and Material Management Service Line (A&MMSL) has established mandatory training on the Generic Inventory Package (GIP) for all users. In addition, the Louisville A&MMSL has started an ongoing one-on-one GIP training program to ensure that all supply inventory management regulations are being met.

Louisville A&MMSL is now tracking inventory accuracy using the Availability Listing, Abbreviated Item report, and Physical Count Form in the GIP package.

Engineering is a stand alone primary without secondaries. Because of the number of employees that would be needed to manage the Engineering inventory in a primary to secondary relationship, the decision was made to conduct weekly inventory distribution postings to secondary inventory points for the stock pulled. This has been an acceptable practice according to the VHA Logistics Office. Engineering performance monitors have been suspended by Deputy Under Secretary for Healthcare Operations and Management.

Louisville A&MMSL will check all primary inventory points with a ten percent sampling of total line items on a monthly basis to ensure inventory accuracy and track results using excel spreadsheets.

PIP Inventory Accuracy:

The employee who is in the position of ordering and posting inventory has received additional training in PIP. The PIP is run each Friday and the Program Support Assistant (PSA) in this position is to verify, and do an inventory count at least one time per month to verify stock levels.

The equipment for the Prosthetics Inventory Package (PIP) bar coding has been received and one employee has been trained on the package. The employee will run a physical inventory of all inventory points in PIP each Friday, and verify the point

(c) implement bar coding for Prosthetics Service supplies.

Concur **Target Completion Date:** May 15, 2005

The (National) patch (RMPR*3*61) for bar coding has just been received by all field facilities. Most of the equipment has been received at the facility and as soon as the patch is loaded and the equipment has been installed, the training will be provided and this package will be implemented fully. This should be functional and running by May 15, 2005.

The Prosthetics staff received training on tracking prosthetics supplies in November 2004. The scanning equipment to conduct bar coding has been received in Prosthetics Service and training will be conducted with full implementation by March 31, 2005.

(d) train Prosthetics Service clerks on use of PIP.

Concur **Target Completion Date:** November 2004

Eight hours of training was provided by Lead Purchasing Agent to the Prosthetics Staff on Prosthetics Inventory Package (PIP) in November 2004. One staff member has been assigned to the position of inputting inventory in to the PIP and posting stock from the PIP to the patient record. This employee has undergone the Purchasing Warranting Program.

Documentation of training is being documented both through the VISTA system and through the competency folder. The completeness of employee actions will be reviewed on a weekly basis by other staff members to assure that the stock orders are posted timely.

(e) conduct annual physical inventories in Engineering Service.

Concur (with Qualifications) **Target Completion Date:** March 31, 2005

According to VHA Handbook 1761.2, paragraph 3. Scope, annual wall-to-wall inventories are required to maintain accuracy. However, it does not address a specific method to accomplish such an audit. In Paragraph 6.b.(5) Program Implementation, it specifically states, "In order to ensure existing GIP accounts are accurate, it is recommended that a 10 percent sampling of line items is verified by physical count and compared to existing data." Consequently, it is our intent to accomplish our annual inventories by targeting 10% of our line items each month for a physical count that will be compared to the GIP records, discrepancies will be noted, and an investigation of the cause for the discrepancy will be conducted and documented, in addition to the corrective action that is taken to prevent future inaccuracies. During the course of a 12-month period, all line items will be physically counted. Inventory accuracy will be tracked using the availability listing, abbreviated item report, and physical count form in the GIP package.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) bill third parties for the missed billing opportunities identified.

Concur **Target Completion Date:** March 2005

The 40 cases identified as missed bill opportunities, 23 were billed and collected. Seventeen are in the process of being billed.

and (b) strengthen review procedures to prevent missed billing opportunities.

Concur **Target Completion Date:** Implemented

The coding staff along with the Chief, Health Information Management are reviewing all encounters not billed due to missing or incomplete medical documentation through the use of a suspension list maintained within QuadraMed, the coding and billing software utilized in VISN 9. These encounters remain on the suspension list and will be followed up on until the documentation is received. The Chief, HIM reviews the list daily, and notices are sent to the clinical services to alert them of the documentation needed. Monthly reports are presented at both the HIMS Committee and the Clinical Executive Board.

The Health Information Chief reviews “Reasons not Billable” report monthly to monitor insufficient and missing documentation. This report is provided to all clinical services for follow-up. The medical center currently monitors 100% of the cases from the “reason not Billable” report identified as having missing or insufficient documentation.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) medication carts are secure.

Concur **Target Completion Date:** Implemented and Ongoing

The Nursing Supervisor will randomly check unattended medication carts to ensure they are locked on all tours.

(b) emergency crash carts are checked according to medical center policy.

Concur **Target Completion Date:** Implemented and Ongoing

Nursing staff on the inpatient units and Emergency Room has been re-educated in the requirements for checking defibrillators outlined in Medical Center Memorandum 11-08.

and (c) patient safety and privacy concerns are corrected in the inpatient mental health unit.

Concur **Target Completion Date:** April 29, 2005

Showerheads were replaced during the inspection. October 29, 2005. Interior door windows will be replaced with units that have blinds for privacy. **April 18, 2005**

Exterior windows will be replaced with units that have blinds for privacy. **April 29, 2005**

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) comply with VA policy to report missing controlled substances to OIG.

Concur **Target Completion Date:** February 14, 2005

When Pharmacy Service discovers the loss or apparent loss of a controlled substance that may represent diversion, Chief, Pharmacy Service will follow Medical Center Memorandum 119-2, REPORTING THE LOSS OF CONTROLLED SUBSTANCES, and contact the OIG and VISN 9 Pharmacy Benefits Manager by email regarding the loss at the same time VA Police are contacted. **February 14, 2005.**

The Controlled Substance Workgroup meets monthly and will report on any losses and verify that OIG has been contacted.

(b) ensure that controlled substances inventory records are complete and available for monthly unannounced inspections.

Concur **Target Completion Date:** Implemented

As stated in the OIG Recommendation local policy change was under review and had been signed by the Director during the inspection. Local Policy implemented was that all Controlled Substance Inventory Records (Green Sheets) will be turned into pharmacy within 48 hours from when a last entry on the inventory sheet has been completed and reviewed by the manager. In addition, weekly reviews of the Inventory Record are conducted to validate both compliance with local policy as well as weekly inventory counts. The monthly inspections are conducted by the Controlled Substance Inspectors, and weekly inspections of inventory sheets are conducted by the Controlled Substance Coordinator (CSC). Non-compliance identified during an unannounced inspection is immediately reported to the CSC for follow up with applicable services. The threshold is 100%: All Controlled Substance Inventory Sheets (Green Sheets) will be made available for inspectors to review during an unannounced inspection, and during weekly checks by the Controlled Substance Coordinator. Implementation occurred the week following the OIG inspections in October 2004 and is Ongoing.

(c) ensure a complete inventory is conducted upon the permanent change of the Pharmacy Service Chief to comply with VA policy.

Concur **Target Completion Date:** February 15, 2005

The current Pharmacy Chief is now aware of the requirement for an inventory to be completed and will ensure a complete controlled substance inventory is conducted concurrent with his departure from the position. An addendum to the Functional Statement for the Chief, Pharmacy Service has been added that states that upon the appointment of the new Chief, Pharmacy, a complete controlled substance inventory will be conducted. The former chief, the new Pharmacy Service Chief, and the facility's officials will sign the record of the inventory.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the use of InterQual® criteria is implemented to determine appropriateness of patient admission and length of stay.

Concur **Target Completion Date:** April 2005

The InterQual Criteria is utilized for all preadmission reviews.

The goal is to implement InterQual Criteria or another resource for continued stay reviews by May 2005 with re-organization of utilization review under Strategic Management Service.

and (b) QM initiatives focus on preventive strategies and alternatives to the use of restraint and seclusion.

Concur **Target Completion Date:** April 2005

Preventive strategies and alternatives to restraints are now displayed on the 04 restraint utilization graphs for tracking and trending of preventive actions and alternatives taken. Quality Executive Board and Clinical Executive Board will review and evaluate the impact on reducing restraint utilization rates monthly to determine outliers.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director takes action to install lockable steel cabinets in the vault or purchase a new Type II vault.

Concur **Target Completion Date:** April 15, 2005

The purchase of lockable steel cabinets meeting Type I security requirements have been ordered to enhance pharmacy cache security. April 15, 2005

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director takes action to correct the Agent Cashier security deficiencies.

Concur **Target Completion Date:** May 9, 2005

Replace existing door with steel door and install peephole.
April 18, 2005

Install new glass in existing pass-through window frame to eliminate reach in. **May 9, 2005**

Install duress alarms at both desks. **April 4, 2005**

Install motion detector and relocate audible alarm. **April 25, 2005**

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires Fiscal Service staff to aggressively and promptly follow up on delinquent accounts receivable and document these collection efforts.

Concur **Target Completion Date:** April 30, 2005

Aged receivable report will be reviewed monthly for follow-up action. All incoming Explanation of Benefits (EOB's) correspondence, and phone calls will be documented with transaction comments diaried for follow-up. A statistical review of outstanding receivables will be conducted every six months. The first statistical review will be performed in April 2005 and will continue to be conducted in six month intervals.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director requires the contracting officer to include all required documents in the contract files.

Concur **Target Completion Date:** May 31, 2005

All contracting officers in VISN 9 are organizationally aligned under the Network Contract Manager in the Acquisition Service Center, consequently they do not report to the Medical Center Director. A new quality technical review process is being established in VISN 9 to assure all required documents are included in the contract files. Contract review reports will be generated for each review conducted and filed in the contract files. This will enable the Supervisor, Head of Contracting Activity, and any outside audit entities to determine that quality reviews are being completed.

Recommended Improvement Action 10. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) audit all cardholder accounts quarterly.

Concur **Target Completion Date:** March 2005

Fill vacant Accountant position to complete audit of all cardholders each quarter. Accountant vacancy filled February 7, 2005. Audits to be completed by end of quarter March 2005.

With the implementation of the Fiscal and Accounting Internal Control Certification Checklist, Fiscal Service will monitor on a quarterly basis to ensure this process is being accomplished in accordance with Regulations.

(b) establish controls to ensure that Government purchase card transactions are timely reconciled.

Concur **Target Completion Date:** Implemented

Fiscal will send twice-weekly reports to all Service Chiefs showing age of any reconciliation over 11 days old, by cardholder. In addition, due to high volume usage, all Prosthetics and A&MM users will be apprised twice weekly of the status of all reconciliations. Actions already implemented. Success reflected in green rating on Financial Indicator for last 4 months.

and (c) comply with VA timeliness standards for approving reconciled purchase card transactions.

Concur **Target Completion Date:** Implemented

The approving officials are to be notified twice weekly by Agency Organization Program Coordinator (AOPC) of items needing approval. Alternate will be appointed to send notifications if AOPC is unavailable. Spreadsheet will be created and sent monthly to Chief, A&MM to track individuals not in compliance. Completing twice weekly notification already. Progress reflected in green rating on Financial Indicator for 3 of last 4 months. Assignment of alternate for weekly notifications and implementation of spreadsheet to notify management of progress will be completed by end of month February 2005.

Recommended Improvement Action 11. We recommend that the VISN Director ensure that the VAMC Director take action to ensure that: (a) operation reports specify the primary surgeon in each case.

Concur **Target Completion Date:** March 1, 2005

VHA policy requires that the operation report in a patient record contain the names of the primary surgeon, attending surgeon and assistants. The dictation instructions will be modified by March 1, 2005 under Begin Dictation and Operative Report Format to include Primary Surgeon, Attending Surgeon and Assistants.

and (b) operations reports document the presence and involvement of the attending surgeon in each case.

Concur **Target Completion Date:** May 1, 2005

VHA policy also requires that the operation report document the presence and involvement of the attending surgeon for the procedure.

The dictation instructions will also be modified under Operative Report Format to include Attending Involvement; i.e.; dictator may select from "The Attending Surgeon performed the procedure as the operative surgeon; the Attending Surgeon was scheduled into the case and directed the procedure; the Attending Surgeon was physically in the operating room in a supervisory position; or the Attending Surgeon was immediately available, physically present in the operative suite." The Health Information Management Committee will provide oversight. As a segment of their overall review of medical records, the Business Office, Medical records Section, will complete a 100% review of operative records to ensure compliance with appropriate documentation of Primary Surgeon and role of Attending Surgeon. Surgical Service will complete a monthly 50-chart review of operative records to ensure compliance with appropriate documentation of Primary Surgeon and role of Attending Surgeon.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
1	Reduce excess inventory levels to a 30-day supply and eliminate unnecessary inactive line items.	\$96,000
2	Strengthen MCCF review procedures to prevent missed billing opportunities.	14,934
	Total	\$110,934

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell Jr. (708) 202-26760
Acknowledgments	Verena Briley-Hudson Paula Chapman Larry Chinn Mark Collins Wachita Haywood Raymond Jurkiewicz Michael Keen Dana Martin Cynnde Nielsen John Pawlik Jennifer Roberts Leslie Rogers Ora Dell Young

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