Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire

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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 Manchester VA Medical Center. The purpose of the review was to evaluate selected medical center 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 62 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 1.

Results of Review

The following organizational strengths were identified:

- The Falls Prevention Program
- The Diabetic Education Program

This CAP review focused on 11 areas. The medical center complied with selected standards in the following areas:

- Controlled Substances Accountability
- Information Technology Security

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

- Correct environment of care deficiencies.
- Strengthen QM through improved data collection and analysis.
- Improve medical record documentation for patients at risk for the development of pressure ulcers.
- Strengthen the Emergency Preparedness Program.
- Strengthen controls to improve oversight of the contracting activity and contract administration.
- Improve administration of the Fee Basis Care Program.
- Improve inventory procedures and controls for nonexpendable equipment.
- Strengthen controls over the Government Purchase Card Program to ensure greater compliance with the Federal Acquisition Regulation (FAR) and VA policy.
- Strengthen controls over time and attendance procedures for radiologists.

This report was prepared under the direction of Ms. Katherine Owens, Director, Bedford Office of Healthcare Inspections.

Facility Director Comments

The VISN Director and Medical Center Directors agreed with CAP review findings and recommendations and provided acceptable improvement plans. (See Appendix C, beginning on page 20, for the full text of the Directors' comments.) We will follow up on implementation of planned actions until they are completed.

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

Introduction

Facility Profile

Organization. Located in Manchester, New Hampshire, the medical center consists of a primary care center, an extended care center, and community-based outpatient clinics (CBOCs) in Tilton, Conway, Wolfeboro, and Portsmouth, New Hampshire. The medical center serves a primary service area that consists of the Lakes Region and Seacoast areas in New Hampshire. Its referral service area includes York County, Maine; and Essex County, Massachusetts.

Programs. The medical center provides primary and secondary care and supports programs in medicine, surgery, and ambulatory care. The continuum of patient services is ensured through primary care, nursing home care, hospital based home care, adult day care, and respite and hospice services.

Affiliations and Research. The medical center is affiliated with Dartmouth Medical School. It also is affiliated with Harvard University's Dental School and the Massachusetts School of Pharmacy. Nursing school affiliations include Northeastern University, University of Lowell, Simmons College, Boston College, Rivier College, and New Hampshire Technical Community College.

During Fiscal Year (FY) 2004, the medical center had 15 active research projects, five of which were post-traumatic stress disorder studies. Research projects also included diabetes, geriatric and advanced illness care, and prostate cancer screening. The research funding for FY 2004 was approximately $825,914.

Resources. The medical center's budget for FY 2003 totaled approximately $62,739,227 million; the FY 2004 budget totaled approximately $76,224,653 million. FY 2003 staffing was 484 full-time employee equivalents (FTE); FY 2004 staffing was 497 FTE, which included 36 physician and 102 nursing FTE.

Workload. In FY 2003, the medical center treated 19,968 unique patients. During FY 2004, 19,993 unique patients were treated. The average daily census for the nursing home care unit was 82 for FY 2003 and 72 for FY 2004. The outpatient workload for FY 2003 totaled 159,061 visits. For FY 2004, workload totaled 167,180 outpatient visits.

Decisions Relating to Recommendations of the VA Commission on Capital Asset Realignment for Enhanced Services (CARES). On February 12, 2004, the CARES issued a report to the Secretary of Veterans Affairs describing its recommendations for improvement or replacement of VA medical facilities. The Secretary published his decisions relative to the Commission's recommendations in May 2004. With regard to Manchester VA Medical Center, the Secretary concluded that the medical center would enhance access to patient care services and meet increased demands for primary, mental

health, and specialty care services through the expansion of existing on-site services, enhanced use of telemedicine technologies, and contracted specialty care services.

You may go to http://www1.va.gov/cares/ to see the complete text of the Secretary's decision.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

Controlled Substances Accountability	Information Technology Security
Emergency Preparedness	Pressure Ulcer Prevention and Management
Environment of Care	Quality Management
Equipment Accountability	Radiologist Time and Attendance
Fee Basis Care Program	Service Contracts
Government Purchase Card Program	

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

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care.

Questionnaires were sent to all employees and 29 responded, which represented only a 6 percent response rate. We did not believe that this response rate was significant enough to make valid conclusions about employee satisfaction, and the Director agreed. However, the results of the 2004 VA National All Employee Survey indicated a high-level of employee satisfaction.

We interviewed 30 patients during the review. The interviews showed a high-level of patient satisfaction, and the results were discussed with medical center managers.

During the review, we also presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 62 employees, 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.

Results of Review

Organizational Strengths

Performance Improvement Initiatives Were Effective. The medical center's Falls Prevention Program reduced injuries related to patient falls by 14 percent. This initiative was highlighted in the Joint Commission on Accreditation of Healthcare Organizations publication Benchmark®, May 2003.

The Diabetic Education Program helped patients manage their blood sugar levels by monitoring patients' hemoglobin A1C (HbA1C)[1] before and after attending diabetic education classes. Of 93 participants who attended diabetic education classes in 2004, 51decreased their HbA1C levels by a least 1 percent, and 25 of those 51 participants decreased their levels by 2 percent or more. This is significant because blood sugar control can help prevent or reduce the severity of complications associated with diabetes.

[1] The HbA1C test is a blood test used to monitor the average blood sugar control for people who have diabetes.

Opportunities for Improvement

Environment of Care – Areas Needed Management Attention

Conditions Needing Improvement. The medical center's environment of care was generally clean. However, medical center management needed to ensure that preventative maintenance inspections are completed, and sharp objects are secured.

Preventative Maintenance Inspections (PMIs). Medical equipment (that is, electric beds and one defibrillator) and non-medical equipment (for example, microwave ovens) were not inspected in accordance with medical center policy. The electric beds had out-dated inspection labels, and the defibrillator and the microwave ovens had no inspection labels. Medical center policy requires that medical equipment have, at a minimum, annual PMIs performed, and that labels be affixed to the equipment to reflect the most current inspections. Non-medical equipment items are required by policy to have safety inspections before they are used in the medical center. Electrical equipment that is not properly inspected could malfunction during use and cause harm to patients and employees. Managers began taking corrective action while we were on site.

Unsecured Sharp Objects. Unsecured sharp objects (for example, razors and scissors) were found in a community bathroom on a long-term care unit. In addition, sharp knives were found in an employee lounge area that was unlocked and could potentially be accessed by patients. Such objects could be used to inflict self-harm or harm to other individuals. VHA regulations require that the medical center environment present minimal risk to patients, employees, and visitors.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) PMIs are completed in accordance with policies and regulations, and (b) sharp objects are secured or removed from areas that can be accessed by patients.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that PMI's will be completed according to a revised medical center policy, and employees on the long-term care units received an in-service about the importance of keeping sharp objects secured. The implementation plans are acceptable, and we consider the issues resolved.

Quality Management – Information Analysis Needed To Be Improved

Conditions Needing Improvement. The QM Program was generally effective. However, information was not consistently collected and analyzed to identify trends that may require improvements. For example, reviews of nine root cause analyses (RCA)[2]

[2] RCA: a process of identifying causal factors that underlie variations in performance.

and the most recent healthcare failure mode and effects analysis (HFMEA)[3] showed that outcome measures were not well developed. Outcome measures are necessary to ensure that implemented improvement actions are monitored for effectiveness. In addition, safety assessment codes (SAC)[4] were not assigned to adverse patient events and close calls. As a result, documentation that actual and potential SAC 3 events were appropriately analyzed to determine root causes was not available. VHA regulations require outcome measures be developed and SAC scores be assigned to ensure that a credible analyses of adverse patient events and close calls are performed.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) appropriate outcome measures be developed to monitor the effectiveness of improvement actions, (b) SAC scores are assigned to all adverse patient events and close calls, and (c) an in-depth analysis of data is completed to identify trends that may require improvement actions.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that appropriate outcome measures were developed to monitor effectiveness of improvement actions, SAC scores are recorded, and managers have been provided with training about statistical analysis. The implementation plans are acceptable, and we consider the issues resolved.

Pressure Ulcer Prevention and Management - Medical Record Documentation Needed To Be Improved

Condition Needing Improvement. Pressure ulcers[5] are common causes of morbidity (i.e., infections) for immobile hospitalized and long-term care patients; consequently, hospital costs and lengths of hospital stays are significantly increased for patients who develop pressure ulcers. Outcome data showed that the medical center had an effective skin care program; however, nurse managers needed to improve medical record documentation.

A review of 10 medical records showed that 8 records did not contain documentation that patients were turned and repositioned as described in their treatment plans. The medical center's skin care policy requires that a turning and repositioning schedule be established for patients who are at risk for the development of (or who already have) pressure ulcers, and nursing policy requires that adherence to the schedule be documented. Without documentation, there is no evidence that proper turning and repositioning of high-risk patients occurred.

[3] HFMEA: a systematic method of identifying and preventing product and process problems before they occur.
[4] SAC: a matrix developed by the VA National Patient Safety Center to determine severity and probability of an event. SAC scores range from 3 (catastrophic) to 1 (minor).
[5] A pressure ulcer is any lesion caused by unrelieved pressure, usually on a bony prominence, that results in damage to underlying tissue.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires documentation that patients are turned and repositioned according to their individualized treatment plans.

The VISN and Medical Center Directors agreed with the finding and recommendation. A skin care committee has been established and will review practice, policy, procedures, and documentation of skin care. A VISN skin care policy will be implemented by June 1, 2005, and will be incorporated into the medical center's skin care plan. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Preparedness – Controls Over Medical Center Access Needed To Be Strengthened

Condition Needing Improvement. The medical center's Emergency Preparedness Program was generally effective. However, there was no policy or process to ensure that non-VA employees (i.e. contractors) were appropriately identified when they entered the medical center. Non-VA employees were not required to sign in at a central location and were not issued temporary VA identification badges. This lack of control over access to the medical center could result in potential risks such as unauthorized persons gaining access to patient care areas. In addition, medical center managers had no way of knowing the number or location of non-VA employees who might require evacuation in the event of a threatened or actual internal disaster.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that all non-VA employees report to a central location to sign in when they enter the medical center and to wear VA identification badges while in the medical center.

The VISN and Medical Center Directors agreed with the finding and recommendation. A policy and procedure that requires all contractors and vendors to sign in at a central location and to wear identification badges while in the medical center was implemented. The implementation plans are acceptable, and we consider the issue resolved.

Service Contracts – Oversight of the Contracting Activity and Contract Administration Needed To Be Improved

Conditions Needing Improvement. VISN and medical center management needed to improve oversight of the contracting activity by appointing a Head of the Contracting Activity (HCA) and strengthening controls to ensure that contracting officers perform responsibilities in accordance with the Federal Acquisition Regulation (FAR) and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 15 contracts valued at $14.8 million from a universe of 25 service contracts valued at $16 million. We identified the following issues that required management attention.

HCA Oversight. Medical center management did not appoint an HCA to provide proper oversight of the contracting activity. The HCA is responsible for implementing and maintaining an effective and efficient contracting program, establishing adequate controls to ensure compliance with VA policy and the FAR, and training purchase cardholders and approving officials on contracting issues.

Since April 2002, the Chief of Purchasing and Contracting from the White River Junction VA Medical Center provided periodic oversight of contracting activities. This employee made biweekly visits to Manchester from April 2002 to July 2004 and weekly visits from August to November 2004. The HCA's responsibilities include reviewing contract files and related supporting documentation. These reviews help ensure the completeness and accuracy of solicitations and contract documentation packages. Supervisory reviews were not performed for any of the 15 contracts we reviewed. Based on the contracting deficiencies we identified, management should appoint an HCA at this facility.

Contracting Officer Performance. Contracting officers are responsible for completing all necessary contracting actions, ensuring compliance with the terms and conditions of the contract, and maintaining files containing records of pre-award and post-award contractual actions. Our review of the 15 contracts found the following contract administration deficiencies:

- Pre-award Contractual Actions. For the 15 contracts, contracting officers did not conduct the required pre-award contractual actions including price analyses for 12 contracts, workload analyses to support the need and level of procurement for 4 contracts, and market research for 7 contracts. Contracting officers did not forward four contracts valued at $500,000 or more to the VA Office of Acquisition and Materiel Management (OA&MM) for legal and technical review. For 8 contracts, Contracting Officer Technical Representative (COTR) designation letters were not prepared. For 12 contracts, contracting officers did not search the Excluded Parties Listing System (EPLS) database to determine whether the prospective contractors were excluded from Federal contracts.

- Post-award Contractual Actions. Contracting officers did not conduct required post-award contractual actions including preparing price negotiation memorandums to document the negotiation process for 13 contracts, initiating background investigations for contract personnel for 10 contracts, and preparing written justifications to extend the contract terms for 6 contracts.

- Board Certification for Urology Services Providers. A $530,000 urology services contract for the period October 2003–September 2006 required that physicians providing contract services be board certified. We found that two contract physicians were not board certified. Services performed by these physicians included outpatient surgical procedures, prostate biopsies, and urgent urology consultations. To ensure

compliance with contract requirements and to maintain high-quality patient care standards, contracting officers need to validate all contract physicians' credentials.

- Attending Physician Services. The medical center had a $62,711 contract ($46,211 for physician services and $16,500 in administrative fees) with a physician to provide attending physician services for VA patients for the period January 2002–September 2004. It is VA policy that the preferred way of purchasing clinical services is through procedure-based contracts, with Medicare rates the benchmark for procedure prices. Contract file documentation indicated it was management's position to execute a contract at or below Medicare rates. However, the contracting officer negotiated a price at 27 percent above the Medicare rate for attending physician services and a $500 per month administrative fee for 24-hour a day, 7-day a week coverage. For the contract period, payments for physician services totaled $182,218 (294 percent over the estimated cost), and administrative fees totaled $16,500. By applying the 27 percent rate that exceeds Medicare rates to the total payments, we estimated the medical center could have avoided paying $49,199 (27 percent x $182,218) if the contracting officer had negotiated the contract in accordance with Medicare rates.

  In addition, a contracting officer executed a new contract valued at $105,300 ($78,300 for attending physician services and $27,000 in administrative fees) with the same contractor for the period October 2004–September 2007. The contracting officer, who said she was unaware of management's position to execute a contract at or below the Medicare rate, negotiated a price at 29 percent over the Medicare rate and increased the administrative fee to $750 per month.

  We determined the estimated cost of attending services for the period October 2004–September 2007 would be $230,202 (294 percent x $78,300). By applying the 29 percent rate that exceeds Medicare rates to the total cost of the contract, we estimate that the medical center could avoid paying an additional $66,758 (29 percent x $230,202) in costs if the contracting officer had negotiated the contract in accordance with Medicare rates.

  In summary, we estimated that contracting officers could have avoided attending physician services costs totaling $115,957 ($49,199 from the negotiated contract rate for the period January 2002–September 2004 + $66,758 from the negotiated contract rate for the period October 2004–September 2007).

- (See Appendix A for a table summarizing the types of contract services acquired, the estimated value of each contract, and the contract administration deficiencies noted.)

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director implements procedures to: (a) strengthen contract management and oversight by appointing an HCA, (b) forward contracts valued at $500,000 or more to OA&MM for legal/technical reviews, (c) ensure contracting officers

correct contract administration and documentation deficiencies, (d) ensure physicians are board certified in accordance with contract requirements, (e) ensure contracting officers negotiate attending physician services contracts at Medicare rates, and (f) conduct periodic reviews to monitor improvements in contracting officer performance.

The VISN and Medical Center Directors agreed with the finding and recommendations. A VISN HCA was appointed, contracts valued at $500,000 or more are being sent for technical/legal review, and contract deficiencies have been corrected. Also, contracting officers will validate contract physicians' credentials according to contract requirements and use Medicare rates as a basis for negotiating physician contracts. In addition, the contracting officer supervisor will review and monitor contracting officer performance. The implementation plans are acceptable, and we consider the issues resolved.

Fee Basis Care Program – Controls to Ensure Accurate Bills and Complete Medical Records Needed To Be Established

Conditions Needing Improvement. Under the Fee Basis Care Program, the medical center may authorize veterans to obtain health care from non-VA providers at VA expense. From October 2003 through September 2004, the medical center's Fee Basis Care Program office paid 10 vendors $7.8 million for hospitalization, cardiology, surgical, anesthesia, and attending physician services. We reviewed the program to determine whether controls were adequate to ensure that fee basis payments for inpatient and outpatient care were appropriate and whether patients' medical records documented the care received from fee providers. Management needed to improve fee basis administration controls to ensure that fee basis bills are reviewed for accuracy and documentation of fee basis care is obtained and included in patient medical records.

Billing Accuracy. VA policy requires that employees ensure the accuracy of fee basis bills. Medical center coders conducted monthly audits of inpatient and outpatient bills to determine billing accuracy. These audits were based on a sample of 40 bills selected each month by VISN personnel. However, we found that fee basis bills were not included in the audits. To validate billing accuracy, the medical center should include a random selection of fee basis bills in the monthly audits.

Completeness of Patient Medical Records. VA policy requires that medical records reflect the results of care provided to patients. To determine if discharge summaries from fee-based episodes of care were included in VA medical records, we reviewed 32 medical records for patients who received fee-based care. We found that discharge summaries for 11 (34 percent) episodes were not recorded in the patient medical records. As a result, the medical center did not have assurance that medical records included a complete history of the patients' care.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) fee basis bills be included in the

monthly audit sample to provide assurance that billing is accurate, and (b) patient medical records include the results of fee basis care.

The VISN and Medical Center Directors agreed with the findings and recommendations. Utilization review employees are reviewing a sample of fee basis bills to ensure accuracy, and copies of fee basis discharge reports are being forwarded to the file room for placement in patients' records. Scanning equipment for the file room will be in place by June 1, 2005, and a process action team (PAT) was activated to ensure that fee basis reports are timely placed in the patients' medical records. The PAT will complete its work July 31, 2005. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Inventories Needed To Be Properly Performed and Controls Needed To Be Strengthened

Condition Needing Improvement. Management needed to improve procedures to ensure that nonexpendable and sensitive equipment is properly accounted for and safeguarded. VA policy requires that periodic inventories be done to ensure that equipment is accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Materiel Management Service (A&MMS) staff are responsible for coordinating the EIL inventories, which includes notifying all services when inventories are due and following up on incomplete or delinquent inventories.

As of November 15, 2004, the medical center had 38 active EILs listing 331 equipment items with a total value of about $9.0 million. We identified four equipment accountability issues that required corrective action.

Equipment Inventory Procedures. VA policy requires that responsible officials (such as service chiefs or their designees) conduct annual or biennial inventories of nonexpendable equipment. These officials must evaluate the need for all equipment assigned to them and sign and date their EILs certifying that equipment was accounted for. We found the following equipment inventory deficiencies:

- Responsible officials did not complete 33 of 38 annual inventories within the required 10-day period after receiving notification that the inventories were due. Nineteen EILs were delinquent from 11 to 30 days, and the remaining 14 EILs were delinquent from 31 to 95 days.

- A&MMS staff and responsible EIL officials had not performed required quarterly spot checks of completed EIL physical inventories to verify the accuracy of reported information.

- A&MMS staff did not ensure that "Reports of Survey" (VA Form 90-1217), which reports equipment as lost, damaged, or destroyed, were properly signed by all

responsible officials. These officials included an accountable officer, an approving authority, and a survey officer. Our review of four Reports of Survey found that all were missing one to three signatures. The reports involved a damaged copy machine (damage estimate = $800), a damaged laptop computer (value = $2,545), a missing laptop computer (value = $2,274), and a missing digital camera (value = $750).

- Twenty-two employees had the capability to add, edit, or delete nonexpendable property data in the EIL database. We found that 20 of these employees did not have a need for access to those database system options. The integrity of the property database was vulnerable to manipulation or misuse because so many people had access to it. During our review, Information Resource Management (IRM) and A&MMS officials addressed this problem and limited database access to two employees.

Accuracy of EILs. To assess equipment accountability, we reviewed a sample of 30 items (combined value = $803,198). We were able to locate 29 of the 30 items. The following discrepancies required further action:

- A physiological recorder/monitor (value = $18,893) could not be located. A&MMS staff indicated the item had been dismantled and parts kept for other use. However, action had not been taken to properly remove it from the active EIL.

- The serial number for a colposcope (value = $6,734) was incorrectly recorded.

We also performed separate reviews of firearms, defibrillators, leased vehicles, and "out of service" equipment items and found the following deficiencies:

- Although we accounted for all 15 firearms assigned to the medical center, 5 were placed in the wrong lock boxes in relation to the respective property barcode labels. The police chief corrected this discrepancy during our review.

- We selected 4 defibrillators (out of 8) to verify the accuracy of EIL data and to determine if preventive maintenance inspection stickers were affixed to the equipment. We found that the locations for three defibrillators were not properly listed on the EILs. Also, one defibrillator was overdue for inspection.

- Sixteen vehicles leased from the General Services Administration (total monthly leased cost = $3,827) were not recorded on an EIL.

- Our review of 64 "out of service" equipment items (value = $233,050) found that A&MMS staff could not locate 9 items (value = $37,803) including a charger (value = $28,041), 2 pulse oximeters (value = $1,700), and a cystoscope (value = $2,656).

Sensitive Equipment. VA policy requires that certain sensitive equipment items be accounted for regardless of cost, life expectancy, or maintenance requirements. Sensitive

items are those (such as computer equipment) that are subject to theft, loss, or conversion to personal use. During FY 2003 and FY 2004, the medical center acquired 548 items of information technology (IT) related equipment (total value = $618,980). To ensure these items were properly recorded and accounted for, we selected a sample of 37 items for review. Twelve items had accountability discrepancies:

- One 17-inch computer monitor (value = $469) could not be found.
- The location of one notebook computer (value = $2,390) was not correctly shown on the EIL.
- Ten other items in an IT storage room (1 desktop computer, one scanner, two printers, and six computer monitors) did not have property barcode labels and were not listed on an EIL.

The storage room also contained 114 items of newly purchased IT equipment (estimated total value = $129,000). Although we did not determine how long this equipment had been stored, IRM officials told us in December 2004 they planned to deploy the equipment in January 2005. Much of the equipment was acquired near the end of FY 2004, and most of it had been delivered to the medical center in October and November of FY 2005. Medical center management should monitor future IT acquisitions to ensure that IT equipment is placed into service as soon as possible.

Loaned Equipment. VA policy requires that equipment loans to employees be made through A&MMS. Also, A&MMS is required to review documentation to make sure that equipment is returned when the loan period expires. The medical center's local policy prescribed a form to be used to document loaned equipment. A&MMS personnel maintained a log to sign out loaned equipment. However, the log did not contain complete and accurate information about loaned equipment (dates loaned, dates returned, and approving official signatures). During our review, A&MMS and IRM officials completed the appropriate documentation for the loaned equipment.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires the Chief of A&MMS to: (a) ensure that responsible officials or their designees perform physical inventories of nonexpendable property in accordance with VA policy, (b) perform quarterly inventory spot checks, (c) ensure that "Reports of Survey" forms are signed by all responsible officials, (d) ensure controls are implemented to restrict EIL database access to only those employees who need it, (e) strengthen controls to account for property listed on the EIL as "out of service," (f) improve procedures to accurately account for sensitive IT equipment, and (g) ensure proper documentation is prepared for loaned equipment.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that EIL reviews are due by May 2005 and quarterly inventory spot checks

will begin in May 2005. Reports of Survey are current and signed by an appropriate official, and access to the EIL data base has been restricted. Items on the Out of Service Equipment list have been located and records updated, procedures to accurately account for sensitive IT equipment have been initiated, and loaned property procedures have been revised. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Compliance with the Federal Acquisition Regulation and VA Policy Needed To Be Improved

Conditions Needing Improvement. Medical center management needed to strengthen controls to ensure that Government purchase cardholders seek competition for open market purchases exceeding $2,500, cardholder and approving official training is documented, and monthly and quarterly audits are conducted as required. Further, controls needed to be strengthened to ensure that the program coordinator (PC) does not reconcile and approve cardholder purchases, documentation is maintained to reconcile charges and certify payments, and equipment is received before vendors charge cardholder accounts. From October 2002 through September 2004, the medical center's 38 cardholders and 15 approving officials processed 21,221 transactions totaling $7.1 million.

Competitive Procurements. Purchase cardholders did not maintain documentation to support competition for purchases exceeding $2,500. The FAR requires that purchasing officials use competition to obtain supplies and services at the best prices. Further, cardholders must consider three sources for competition or document the justification for using a sole source.

We reviewed a sample of 30 open market transactions totaling $181,616 processed by one cardholder and one approving official and evaluated the extent of competitive purchasing efforts. We found that a cardholder did not obtain competitive bids from three sources or document sole source justifications for eight purchases totaling $37,503. The eight purchases were for five listening devices totaling $17,863, two stair-glides totaling $13,620, and one wheelchair totaling $6,020. Because they did not obtain competitive bids, cardholders did not have reasonable assurance that the best prices were obtained or that procurements were made in VA's best interest.

Cardholder and Approving Official Training. VA policy requires the HCA and the PC ensure the cardholders and approving official receive acquisition training and that this training is documented. Training was not documented for 19 (50 percent) of 38 cardholders and 10 (67 percent) of 15 approving officials. The lack of documented training of cardholders and approving officials further supported the need for management to appoint a HCA.

Monthly and Quarterly Audits. VA policy requires that the fiscal officer, using a statistical sampling of purchases provided by the VA Financial Service Center (FSC), conduct monthly audits of cardholder accounts. VA policy also requires the PC and the fiscal officer to conduct joint quarterly audits of cardholders and approving officials.

We reviewed nine monthly audits and found that the audits were not completed properly. The chief accountant did not review documentation (such as invoices, packing slips, or cash register receipts) supporting 15 purchases totaling $12,350. The PC and fiscal officer did not maintain documentation that joint quarterly audits were conducted of cardholders and approving officials.

Reconciliations and Certifications. VA policy requires cardholders to reconcile charges to their accounts and approving officials to certify transactions as legal and proper. VA policy prohibits the PC from reconciling charges to cardholder accounts and certifying transactions. However, we found that the PC reconciled 51 transactions totaling $17,914 made by 12 cardholders and certified 904 transactions totaling $396,813 made by 7 cardholders. The PC stated she performed these tasks because cardholders and approving officials were either on leave, had transferred, or had retired.

Receipt Documentation. VA policy requires purchase cardholders to maintain documentation verifying the receipt of goods so that approving officials have support for certifying payments. We found that a cardholder reconciled charges, and an approving official certified payments without documentation (such as invoices, packing slips, or cash register receipts) to support 12 purchases totaling $57,820. The 12 purchases included 6 stair-glides totaling $34,550, 4 wheelchair/scooter lifts totaling $13,710, an electric wheelchair totaling $6,020, and a listening device totaling $3,540.

Cardholder Accounts Charged By Vendor. VA policy requires cardholders and approving officials ensure vendors do not charge cardholder accounts until the purchased goods or services are delivered or performed. We reviewed a sample of 30 purchases and found that for 7 purchases (4 stair-glides, 2 wheelchair lifts, and a wheelchair) totaling $41,750, the vendor charged the cardholder account for these items before delivering them to veterans. The cardholder and approving official processed these payments from 3 to 108 days before veterans received the equipment.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) cardholders document that competition was sought for purchases over $2,500 or document sole source justifications, (b) the HCA and the PC document cardholder and approving official training, (c) the PC maintains documentation supporting monthly audits, (d) joint quarterly reviews are conducted, (e) the PC not reconcile or certify cardholder transactions, (f) cardholders obtain sufficient documentation to enable approving officials to verify receipt of goods and services, and (g) cardholders and approving officials ensure vendors do not charge cardholder accounts before the delivery of goods.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that by May 2005 purchase cardholders will document that competition was sought for purchases over $2,500, and training for cardholders will be implemented and documented. Also, monthly audits will be documented, joint quarterly reviews will be conducted, and the PC will no longer reconcile or certify cardholder transactions. In addition, cardholders will obtain documentation from vendors to enable approving officials to verify receipt of goods and services, and vendors will be notified that they may not charge cardholder accounts before the delivery of goods. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Radiologist Time and Attendance – Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to strengthen controls to ensure that a full-time medical center radiologist follow time and attendance procedures and submit leave requests for time not worked. VA policy requires that all leave, with the exception of unscheduled sick leave, be requested in Veterans Information Systems and Technology Architecture system prior to being used. During the 4-year period FY 2001 to 2004, a radiologist was paid for time when he was absent and for which he did not submit official leave requests. Also, a second radiologist did submit leave requests, but the leave was not posted and charged against his leave balance, as required. Further, timekeepers, certifying supervisors, and the Employee Accounts Section (payroll office) did not perform their duties as required. As a result, a radiologist was improperly paid for time he did not work, and a second radiologist was not charged for submitted leave requests.

Management conducted a leave audit, which found that one radiologist had not submitted requests for 15 days of annual leave and 31 days of sick leave. The other radiologist had submitted requests for 10 days of annual leave, but the leave had not been posted to his timecard or deducted from his leave balance.

We determined that fundamental timekeeping controls were not enforced. Employees are responsible for notifying timekeepers of all leave and for reviewing their earning and leave statements for accuracy. The two radiologists did not meet those responsibilities. Timekeepers are responsible for preparing time and attendance records and must have knowledge when each employee is on duty. Supervisors are responsible for assuring certification and posting of time and attendance. The timekeepers and certifying supervisors did not meet their responsibilities.

Also, the payroll office did not comply with VA policy requiring timekeeper desk audits. These audits determine whether all timekeeping exceptions are reported to the timekeepers and certifying officials for corrective action. Some of the timekeeping discrepancies pertaining to the two radiologists would have appeared in the timekeeping

system as leave exceptions, which should have been addressed by the timekeepers or supervisors. Since the exceptions were not appropriately addressed, the payroll office should have identified them on a leave exceptions report, which they are required to run on a semiannual basis. However, we were told the exceptions report was "flushed" from the timekeeping system (wiped out without resolving the problems).

Because of the seriousness of the leave abuse problem, the Medical Center Director convened an Administrative Investigation Board to investigate the timekeeping practices for the two radiologists.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) appropriate action be taken concerning the time and attendance of the two radiologists, (b) the payroll office provide time and attendance refresher training to all physicians, timekeepers, and certifying supervisors, (c) the payroll office clear timecard exceptions in a timely manner and, (d) the payroll office conduct timekeeper desk audits and oversee reconciliation of timekeeping exceptions that are not cleared in a timely manner.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that appropriate administrative action was taken concerning the time and attendance issues, and training about time and attendance requirements was provided to appropriate employees. In addition, timecard exceptions will be cleared timely, and the civilian pay technician is currently conducting desk audits. An independent internal audit of payroll will be conducted in the near future. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

Service Contract Administration Deficiencies

Contract Deficiencies	Ambulance Services $2,589,886	Mailroom/ Switchboard Services $913,701	Readjustment Counseling Services $150,000	General Surgery Services $556,362	Urology Services $536,900	Cardiology Services $749,608	Cardiology Services $738,090	Acute Care Services $4,300,000	Ophthalmology Services $1,283,145	Infectious Disease Services $246,800	Neuro-Rehabilitation Services $285,430	Neuro-Rehabilitation Services $434,846	Family Health CBOC $500,000	Saco River Conway CBOC $1,500,000	Admitting Physician Services $62,711
HCA Responsibilities															
HCA oversight of contracting activity not provided	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Contracts not reviewed by contracting officer with equal or higher warrant level	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Contracting officer not warranted to execute contract			X								X	X			
Prices appear to be unreasonable												X			X
COTRs not trained	X												X	X	X
Contracting Officer Responsibilities															
Workload analysis not conducted				X									X	X	X
Statement of work not clear/contract requirements not well defined	X			X	X						X	X			
Market research not conducted	X				X		X		X		X	X			X
Solicitation not adequately advertised	X				X				X	X					X
Legal/technical review not conducted							X	X					X	X	
EPLS database search not conducted	X			X	X	X	X	X	X		X	X	X	X	X
Price analysis not conducted	X		X	X	X	X	X		X		X	X	X	X	X
Price negotiation memorandum not prepared	X		X	X	X	X	X		X	X	X	X	X	X	X
Physicians not board certified					X										
Malpractice insurance not current						X								X	
Abstract of offers not prepared	X			X	X				X				X	X	X
Background investigations of contract personnel not conducted		X		X	X	X	X	X	X				X	X	X
COTR letter not prepared					X	X		X			X	X	X	X	X
Written justification to exercise option not prepared	X	X	X	X		X									X
VA employees other than COTR certified payments	X				X		X		X						

Appendix B

VISN 1 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2005

From: VISN 1 Director

Subject: **Manchester VA Medical Center Manchester, New Hampshire**

To: Assistant Inspector General, Office of Healthcare Inspections (54)

Attached is the response to the Draft CAP Report for the Manchester VA Medical Center review.

If you have any questions, please contact Susan Kimmey, Acting Director of the Manchester VA Medical Center at 603-626-6549.

(original signed by:)

Jeannette A. Chirico-Post, MD

Appendix C

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 3, 2005

From: Medical Center Director

Subject: **Manchester VA Medical Center Manchester, New Hampshire**

To: Office of Healthcare Inspections

Thank you for your review that we received on April 21, 2005 and the opportunity to reply to your recommendations. We concur with the recommendations and the monetary benefits in 5e.

We were pleased to see that your interviews showed a high level of patient satisfaction. Our own internal reviews indicated as much but it was nice to have the OIG confirm this fact.

If you have any questions about our responses and would like to address them please contact Louise Caputo, Compliance Officer.

(original signed by:)

SUSAN J. KIMMEY, RD.

ACTING MEDICAL CENTER DIRECTOR

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 requires that: (a) PMIs are completed in accordance with policies and regulations, and (b) sharp objects are secured or removed from areas that can be accessed by patients.

Concur **Target Completion Date:** July 2005

a. It should be noted that in VISN 1, electric beds are listed as non-medical equipment, and the defibrillator questioned was only used for training. Clinical Engineering Service updated all required maintenance stickers on the defibrillator on 12/08/04, during the OIG visit. The Non-medical equipment Policy is being revised to incorporate the VISN Clinical Engineering Assessments Tool. Once revised, PMI's on non-medical equipment will be restructured accordingly. The expected completion date is 07/31/05.

b. Staff on the two nursing home units received training on proper storage requirements for sharps and keeping medication carts locked for the safety of the patients. Training was completed on 12/09/04, during the OIG visit.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) appropriate outcome measures be developed to monitor the effectiveness of improvement actions, (b) SAC scores are assigned to all adverse patient events and close calls, and (c) an in-depth analysis of data is completed to identify trends that may require improvement actions.

Concur **Target Completion Date:** 06/30/05

a. Appropriate outcome measures have been implemented to monitor the effectiveness of improvement actions for all RCAs and FMEAs. Implemented as of January 01, 2005.

b. Safety Assessment Codes have always been assigned to all incidents as documented in the actions assigned to each incident. Since January 1, 2005 all SAC scores are recorded in a new column on the excel worksheet used by the Patient Safety Risk Manager.

c. All top leaders have been provided with a training CD on statistical analysis. Data management videotapes have been obtained. All data is reviewed at the weekly Quality Executive Board (QEB) meeting. The Local Service Line Managers (LSLM) have the responsibility of documenting and analyzing the data and reporting the data to the QEB, on a quarterly basis with action plans. Trends and analyses found throughout the year are acted upon by the LSLMs as recommended/assigned by the QEB, of which the Quadrad are members.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires documentation that patients are turned and repositioned according to their individualized treatment plans.

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

The Manchester facility has implemented a skin care committee to review practice, policy, procedures and documentation surrounding skin care across care lines. This is an interdisciplinary committee which meets monthly. C.N.A. staff turn patients at risk and in bed q2 hours as a standard of care and we have incorporated this documentation in the ADL flow sheet. A VISN Policy will be established by June 1, 2005 and we will incorporate it into our Plan.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that all non-VA employees report to a central location to sign in when they enter the medical center and to wear VA identification badges while in the medical center.

Concur **Target Completion Date:** February 2005

As of February 1, 2005 the Medical Center has established a Policy and Procedures that requires all contractors, vendors, etc. (other than visitors) to sign in with the Telephone Operator at the main entrance. The operator issues a temporary badge which automatically expires after 24 hours. The VA Police supervise and have overall responsibility for the program.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director implements procedures to: (a) strengthen contract management and oversight by appointing an HCA, (b) forward contracts valued at $500,000 or more to OA&MM for legal/technical reviews, (c) ensure contracting officers correct contract administration and documentation deficiencies, (d) ensure physicians are board certified in accordance with contract requirements, (e) ensure contracting officers negotiate attending physician services contracts at Medicare rates, and (f) conduct periodic reviews to monitor improvements in contracting officer performance.

Concur **Target Completion Date:** March 2005

a. The VISN 1 Director has appointed a VISN HCA effective December 2004. Supervisory oversight is provided by WRJ Contracting, and weekly visits have been made as of June 28, 2004 by WRJ. Both the VISN HCA and Supervisor will provide oversight for the contracting activity. Review of a contract checklist and the regulations have been done and documented for all staff. Completion date was December 2004.

b. Since December 9, 2004, all contracts valued at the $500,000 threshold or over are forwarded for legal/technical review as required by regulations.

c. Contract deficiencies have been corrected and are up to date; they are reviewed on the 1st of every month. All contracts now contain a checklist of what has to be accomplished and a contract administration file with the current COTR contact name. All data collected is reported to the QEB meeting on a regularly scheduled basis. Completion date was December 2004.

d. Contracting officers will validate contract physicians' credentials prior to providing services in accordance with contract requirements.

e. Contracting officers will use Medicare rates as a basis for negotiating a new attending physician contract. The intention at the end of the first year of the current contract is to not exercise the future options but to go out for new solicitations.

f. Since December 2004, the Contracting Officer Supervisor has used the checklist to review and document contracting officer performance.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) fee basis bills be included in the monthly audit sample to provide assurance that billing is accurate, and (b) patient medical records include the results of fee basis care.

Concur **Target Completion Date:** 07/31/05

a. Since January 1, 2005, Utilization Review staff have been reviewing a sample of fee basis bills to ensure that billing is accurate. HIMS Coding will review the fee basis consult/discharge reports as part of the monthly audit beginning with April 2005.

b. A copy of fee basis discharge reports is made and forwarded to HIMS coding and to the file room to be placed in the patient record. Outpatient consult reports are being sent to the file room to be placed in the patient chart. The Medical Records department will be receiving scanning equipment for the file room by June 1, 2005. A PAT Team has been activated to look at the duties of the file room personnel to assure that reports are placed in the patient record file in a timely manner. Target Completion date 07/31/05. Radiology has been scanning in outpatient consult reports for MRIs and Mammograms into patient records. Effective Date: February 1, 2005.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires the Chief of A&MMS to: (a) ensure that responsible officials or their designees perform physical inventories of nonexpendable property in accordance with VA policy, (b) perform quarterly inventory spot checks, (c) ensure that "Reports of Survey" forms are signed by all responsible officials, (d) ensure controls are implemented to restrict EIL database access to only those employees who need it, (e) strengthen controls to account for property listed on the EIL as "out of service," (f) improve procedures to accurately account for sensitive IT equipment, and (g) ensure proper documentation is prepared for loaned equipment.

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

a. The EIL has been reviewed and all errors and deficiencies have been resolved, and to prevent future problems, training is being given to EIL officials. EIL reviews by services are due in May 05. They will be going out over the Director's signature and the timelines will be indicated and adhered to. Target Date: 10 days after service receipt, in the Month of May 05. Training is being given to all EIL officials to make sure they understand the timeline.

b. Effective May 2005, A&MM began conducting quarterly spot property checks. A report will be presented to the QEB committee on a regularly scheduled basis.

c. All reports of Survey are now current and signed by appropriate Officials. Completion date: January 2005.

d. The list of personnel found to have access to database to enter or remove equipment was reviewed and unnecessary names were removed. This was completed on 12/08/04, during the OIG visit.

e. All items on the Out of Service Equipment list have been located, records updated and documented on the checklist, or Reports Of Survey have been completed. Completion Date: 4/15/05

f. IRMS has initiated an SOP for the Receipt/Processing and proper Disposal of all ADP equipment, to include sensitive equipment, with A&MM. The SOP contains the required receipt procedure, the tagging and inspection of all the equipment. IRMS will update the location field when the equipment is placed into service. Prior to disposal or release of the ADP equipment, the CIO is required to certify that all sensitive data has been removed and a certificate of cleaning generated by the overwrite software will be maintained by the ISO. All IT equipment no longer needed by the Medical Center will be turned into Property Management. Once approved, Property Management will forward the email to the Warehouse to coordinate pick up. Equipment records will then be adjusted to remove the item(s) from the IT inventory

g. Loan property procedure used for IT equipment have been revised according to the requirements of the local A&MM Policy. Proper documentation will be maintained for all loaned equipment. Completion Date: January 2005.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) cardholders document that competition was sought for purchases over $2,500 or document sole source justifications, (b) the HCA and the PC document cardholder and approving official training, (c) the PC maintains documentation supporting monthly audits, (d) joint quarterly reviews are conducted, (e) the PC not reconcile or certify cardholder transactions, (f) cardholders obtain sufficient documentation to enable approving officials to verify receipt of goods and services, and (g) cardholders and approving officials ensure vendors do not charge cardholder accounts before the delivery of goods.

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

a. Cardholders will document that competition was sought for purchases greater than $2,500 or document sole source justifications. An abstract of offers SF-1409 will be used to document competition.

b. Training will be documented on VA Form 0242 and completed for all cardholders. All signatures, including that of the VISN HCA, should be obtained by the end of May. VA Form 3913 (Department of VA Training Course Report) has been completed and is on file documenting that all cardholders and approving officials have participated in the annual training conducted during December 2004.

c. The documentation of monthly audits will be tracked in two different ways. The PC will maintain a form of each audit conducted. A spreadsheet is updated monthly showing the date of the audit, number of purchase orders reviewed and comments on what was discussed with the cardholder. Audit reviews and outcomes are monitored by the QEB.

d. The PC and the Chief Accountant will conduct the joint quarterly reviews as required.

e. The PC will no longer reconcile or certify cardholder transactions. Surrogate cardholders and/or alternate approving officials have been assigned in order that PC does not perform reconciliations or certifications of cardholder transactions in the future.

f. Cardholders will obtain sufficient documentation from vendors to enable approving officials to verify receipt of goods and services. As part of the audit process, receipt for goods and services will be obtained and reviewed.

g. Cardholders will advise vendors when placing an order that they are prohibited from billing VA until the purchased goods or services have been delivered or performed as required.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) appropriate action be taken concerning the time and attendance of the two radiologists, (b) the payroll office provide time and attendance refresher training to all physicians, timekeepers, and certifying supervisors, (c) the payroll office clear timecard exceptions in a timely manner and, (d) the payroll office conduct timekeeper desk audits and oversee reconciliation of timekeeping exceptions that are not cleared in a timely manner.

Concur **Target Completion Date:** May 2005

a. An Administrative Investigation Board was appointed in December 2004 to review the time and attendance records of the two Radiologists. The ABI report was shared with the OIG. Appropriate administrative action has been taken.

b. Training for all full-time Title 38 practitioners on AL, SL, in lieu of requirements has been provided through both in-house education, coordinated through Fiscal, HR, the Clinical Affairs Office at the yearly Medical Staff meeting held in April 2005. We have also provided all Title 38 providers with current leave policies. The Civilian Pay Technician will develop and present the annual timekeeping training in May 2005. The role of the Leave Approving Official and the Timecard certifiers will be included. We plan to present a Certifying Official Training session. All new Timekeepers and Certifiers will be trained before assuming duties and responsibilities of those functions.

c. The Civilian Pay Technician will continue to monitor and notify responsible care line certifiers and approving personnel, at the end of each pay period, of the need to clear timecard exceptions. The data is reported to the Chief accountant and the CFO.

d. The Civilian Pay Technician is currently conducting face to face bench audits and has currently completed 60 percent of the audits as of April 29, 2005. An independent internal audit of payroll will be conducted by WRJ in the near future. Timecard exceptions and reconciliations are part of a performance improvement report that is presented to all the timekeepers and the certifiers.

Appendix D

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5e	Better use of funds by negotiating attending physician services costs in accordance with Medicare rates.	$115,957
	.	
	Total	$115,957

Appendix E

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, Director, Bedford Office of Healthcare Inspections (781) 687-2317
Acknowledgments	Annette Acosta Maureen Barry John Cintolo Maureen Hamilton David Irwin Mathew Kidd Amanda MacGee Jeanne Martin James McCarthy Philip McDonald Amy Mosman Steven Rosenthal Joseph Vivolo

Appendix F

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