Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Alaska VA Healthcare System Anchorage, Alaska

Report No. 05-02240-206 **September 22, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of July 18–22, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Alaska VA Healthcare System, which is part of Veterans Integrated Service Network (VISN) 20. 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 266 employees, including 25 regional office employees.

Results of Review

The CAP review covered 16 operational activities. The healthcare system complied with selected standards in the following nine activities:

- Colorectal Cancer Management
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- Fee-Basis Care
- Information Technology Security
- Laboratory and Radiology Services
- Quality Management

We identified the following organizational strength:

- A VA-initiated statewide patient safety group successfully increased awareness of common patient safety goals and issues.

We identified seven activities that required additional management attention and made the following six recommendations to improve operations in these activities.

- Improve physical security in the pharmacy and agent cashier office.
- Arm VA police officers who are trained and qualified.
- Strengthen fee-basis insurance billing procedures for the Medical Care Collections Fund (MCCF).

- Reduce excess medical supply inventory, and improve inventory management controls.
- Strengthen administrative oversight over the Government Purchase Card Program.
- Strengthen documentation of the contract award process.

This report was prepared under the direction of Ms. Claire McDonald, Director, and Ms. Melinda Toom, CAP Review Team Leader, Seattle Audit Operations Division.

VISN 20 and Healthcare System Director Comments

The VISN and Healthcare System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 12–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JON A. WOODITCH
Acting Inspector General

Introduction

Healthcare System Profile

Organization. Based in Anchorage, AK, the healthcare system is collocated with a Veterans Benefits Administration regional office, which is managed by the Salt Lake City Regional Office. The healthcare system provides outpatient services at the main ambulatory care clinic in Anchorage and at community-based outpatient clinics (CBOCs) in Fairbanks and Kenai, AK. Inpatient care is provided through fee-basis arrangements with various community hospitals statewide and through a joint venture with the Elmendorf Air Force Base hospital in Anchorage. The healthcare system serves a veteran population of about 72,000 in a primary service area covering the entire State of Alaska.

Programs. The healthcare system provides primary care, mental health services, and limited specialty care, including dermatology, ambulatory surgery, podiatry, and neurology. Most specialty care, such as cardiology and urology, is provided by VISN 20 tertiary care medical centers, based on availability, or by non-VA providers on a fee basis. The healthcare system operates a 50-bed Domiciliary Residential Rehabilitation Treatment Program and a 24-bed Psychiatric Residential Rehabilitation Treatment Program.

Affiliations and Research. The healthcare system is affiliated with the University of Alaska in Anchorage and supports training programs in social work, nursing, medical technology, radiology technology, and dentistry. The healthcare system also has an affiliation with the University of Washington School of Medicine under which third year students in the school's Family Practice Program see VA patients at the Anchorage clinic and a nearby community hospital.

Resources. The healthcare system's fiscal year (FY) 2005 medical care budget was $100.7 million, a 2 percent increase over FY 2004 funding of $98.7 million. FY 2004 staffing was 405 full-time equivalent employees (FTE), including 34 physician FTE and 105 nursing FTE.

Workload. In FY 2004, the healthcare system treated 13,006 unique patients, a 6 percent increase from 12,253 unique patients in FY 2003. The combined outpatient workload for the Anchorage clinic and the Fairbanks and Kenai CBOCs was 90,434 visits. The number of admissions to non-VA hospitals totaled 1,569 (826 to community hospitals and 743 to the Elmendorf Air Force Base hospital). The combined average daily census for the domiciliary and the psychiatric residential program was 35.4.

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 management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. 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 16 activities:

Agent Cashier	Information Technology Security
Colorectal Cancer Management	Laboratory and Radiology Services
Community Nursing Home Contracts	Medical Care Collections Fund
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Equipment Accountability	Security and Law Enforcement
Fee-Basis Care	Service Contracts
Government Purchase Card Program	Supply Inventory Management

The review covered healthcare system operations for FYs 2002 to 2005 through June 2005 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the healthcare system (*Combined Assessment Program Review of the Alaska VA Healthcare System and Regional Office*, Report No. 01-02016-13, October 15, 2001).

As part of the review, we used interviews to survey patient satisfaction with the quality of care. We interviewed 30 patients during the review and discussed the results with healthcare system managers.

We also presented 8 fraud and integrity awareness briefings for 266 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 5–10). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Organizational Strength

VA-Initiated Patient Safety Group Successfully Increased Awareness of Common Patient Safety Goals and Issues. In November 2002, the healthcare system Patient Safety Manager invited five Patient Safety Managers from other Anchorage medical facilities to work together to improve patient safety. Over the next few years, facilities in Fairbanks, Soldotna, and Bethel joined the group, which included for-profit, not-for-profit, and Federal facilities. These organizations agreed to cooperate on patient safety issues, even though some of them are competitors in the same market. Results to date include drafting a statewide charter, standardizing surgical site marking using the VA model, and sharing educational opportunities.

Opportunities for Improvement

Physical Security – Pharmacy and Agent Cashier Security Should Be Improved

Conditions Needing Improvement. We reviewed physical security in the pharmacy and agent cashier office to determine if controls were adequate to prevent unauthorized access. Access controls were generally effective. However, we identified two physical security deficiencies in the pharmacy and one in the agent cashier office that needed correction. All three deficiencies had also been cited in the VA Police Chief's annual security inspection reports since FY 2003.

Pharmacy Wall. The wall surrounding the dispensing window was constructed of drywall, not concrete or a similar material that would provide protection from firearms as required by VA policy. We also identified this issue during the 2001 CAP review. Healthcare system management reported that they considered constructing a concrete wall as a result of the previous review; however, the pharmacy floor could not support the additional weight. They acknowledged that other alternatives were not considered or discussed with officials in the Veterans Health Administration (VHA) Pharmacy Benefits Management Strategic Health Group or the VA Office of Security and Law Enforcement.

Pharmacy Windows. The pharmacy's exterior windows did not have steel security mesh screening as required by VA policy. Subsequent to the 2001 CAP review, healthcare system staff installed security bars, but the bars did not meet VA requirements.

Agent Cashier Wall. The wall that surrounded the transaction window in the agent cashier office was constructed of drywall, not concrete as required by VA policy.

Recommendation 1. We recommended that the VISN Director ensure that the Healthcare System Director coordinates with VHA and VA officials to ensure that the pharmacy wall and exterior windows and the agent cashier wall meet VA security standards.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that they will pursue waivers from implementing the security requirements until a new medical facility is completed in calendar year 2009. However, if they are unsuccessful in obtaining waivers from VHA and VA officials, they will ensure that the deficiencies are corrected. The target completion date is April 28, 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Security and Law Enforcement – VA Police Officers Who Are Trained and Qualified Should Be Armed

Condition Needing Improvement. VA police officers assigned to the healthcare system are unarmed and therefore unable to perform the full scope of their law enforcement duties. VA policy authorizes on-duty police officers at all VA facilities to carry firearms, providing they meet training and qualification requirements. In December 2003, the healthcare system received firearms for its police officers. However, as of July 2005 the officers were still unarmed. This issue was also cited by the VA Office of Security and Law Enforcement during an inspection conducted June 27–July 1, 2005.

Recommendation 2. We recommended that the VISN Director ensure that the Healthcare System Director immediately implements the recommendation of the VA Office of Security and Law Enforcement to arm all VA police officers who are trained and qualified.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that as of August 22, 2005, all VA police officers had met training and certification requirements and were carrying firearms. The improvement plan was acceptable. We consider the issue resolved.

Medical Care Collections Fund – Fee-Basis Insurance Billing Procedures Should Be Strengthened

Condition Needing Improvement. The healthcare system had effective controls over fee-basis insurance billings. However, it could increase its fee-basis MCCF collections by billing insurance carriers for applicable home health care payments. Under the MCCF program, VA medical facilities are authorized to bill health insurance carriers for treatment of insured veterans. In FY 2004, the healthcare system billed insurance companies $13.3 million for fee-basis care and collected $5.8 million (44 percent).

For the 3-month period October 1 through December 31, 2004, the healthcare system paid fee-basis providers $1.4 million for outpatient care and $301,770 for inpatient care for VA patients who had health insurance. To determine whether the healthcare system had billed insurance carriers appropriately for fee-basis care, we reviewed a statistical sample of 22 outpatient payments (value = $5,398) and 11 inpatient payments (value = $64,505). We identified one opportunity for increased collections.

Of the 22 outpatient payments, 2 billable home health care claims (value = $290, or 5 percent of the outpatient sample payments) had not been billed. According to the MCCF section chief, the healthcare system did not routinely bill insurance carriers for home health care charges because of a staff vacancy. By routinely billing insurance companies for home health care, insurance billings could be increased by an estimated $70,000 per

quarter ($1.4 million x 5 percent) or $280,000 per year ($70,000 x 4 quarters). Based on the healthcare system's FY 2004 average insurance collection rate of 44 percent, this could result in additional insurance collections of about $123,200.

Recommendation 3. We recommended that the VISN Director ensure that the Healthcare System Director requires that MCCF staff begin billing insurance carriers for qualified home health care services.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that plans have been implemented to hire additional MCCF staff to bill insurance carriers that had not been previously billed for qualified home health care services. The target implementation date is December 31, 2005. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Supply Inventory Management – Excess Medical Supply Inventory Should Be Reduced and Controls Improved

Conditions Needing Improvement. The healthcare system needed to manage supply stock levels more effectively and make better use of automated inventory controls. VHA policy establishes a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Inaccurate Inventory Records. Supply Processing and Distribution (SPD) Section staff used GIP to manage medical supply inventory. As of May 31, 2005, the inventory consisted of 541 items with a value of $54,095. To test the accuracy of the GIP inventory levels, we reviewed a judgment sample of 20 medical supply items (value = $9,078). We compared the recorded GIP quantities on hand with our actual counts. The on-hand inventory value was $10,030 compared to the GIP inventory record value of $9,078, a difference of $952 (10 percent). If inventory balances are not kept current, GIP cannot accurately track item demand and establish reasonable stock levels and reorder points.

Excess Medical Supply Inventory. Using the same 20 sample items, we found 13 of the items had stock on hand that exceeded the healthcare system's needs, with inventory levels ranging from 35 days to 14 years of supply. The estimated value of stock exceeding 30 days was $3,992, or 44 percent of the total value of the 20 items. By applying the 44 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of the medical supply inventory exceeding current needs was $23,802 (44 percent x $54,095). The excess stock occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-day standard.

Recommendation 4. We recommended that the VISN Director ensure that the Healthcare System Director requires SPD staff to (a) keep GIP inventory records current by promptly and accurately posting inventory transactions and (b) monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that as of August 2005, inventory transactions were being promptly posted, item usage rates were being monitored, GIP stock levels had been adjusted, and excess medical supply inventory had been reduced. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Government Purchase Card Program – Administrative Oversight Should Be Strengthened

Condition Needing Improvement. Healthcare system management and the Purchase Card Coordinator (PCC) needed to ensure that the Government Purchase Card Program was administered effectively. VHA policy requires that only authorized cardholders use assigned purchase cards. For cardholders terminating VA employment, healthcare system policy on exit procedures requires approving officials to certify that cardholders either do not have outstanding purchase card orders or have sufficient documentation so that replacement cardholders can complete outstanding orders.

We reviewed purchase card use for the 12-month period July 2004–June 2005. During this period, 57 cardholders made 9,857 purchase transactions totaling about $6.1 million. From a judgment sample of 50 transactions, we identified 2 purchases that were inappropriately completed by a section chief who used a card after the cardholder terminated employment. This occurred for two reasons: (1) the approving official did not follow exit procedures, which prevented Fiscal Service staff from identifying two purchase card orders that the employee made in October 2003 but had not completed when he left VA and (2) the section chief, PCC, and approving official did not adequately understand VA policy pertaining to the Government Purchase Card Program.

When the cardholder terminated employment in July 2004, the PCC properly closed his purchase card account. However, approximately 8 months later, the section chief requested that the PCC reopen the account and completed the two transactions. The approving official certified both transactions made on the former cardholder's account as legal and proper. Although the purchases were for legitimate VA purposes, the use of the former employee's cancelled purchase card did not comply with internal controls that are in place to prevent fraudulent transactions.

Recommendation 5. We recommended that the VISN Director ensure that the Healthcare System Director requires additional training for the PCC and all cardholders and approving officials on following proper exit procedures and purchase card policies.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that as of August 2005, local policy had been amended to prohibit the reactivation of purchase cards for former employees and an electronic training program on proper exit procedures was being developed for cardholders and approving officials. The target implementation date for the electronic training program is October 15, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Service Contracts – Documentation of the Contract Award Process Should Be Strengthened

Conditions Needing Improvement. The healthcare system needed to improve documentation of the contract award process. The Federal Acquisition Regulation (FAR) and VA policy requires that contracting officers obtain a legal and technical review for competitive contracts over $1.5 million, conduct cost or price analyses for negotiated purchase contracts, evaluate contractor suitability, and maintain documentation of all contracting actions. As of July 1, 2005, the healthcare system had 71 contracts (estimated combined annual cost = $8.0 million). To determine if contract administration and negotiation procedures were effective, we reviewed 10 service contracts (estimated combined annual costs = $3.1 million). Five of the 10 contracts were competitive and 5 were noncompetitive. Generally, the contracts were awarded in compliance with the FAR and VA requirements. However, we found three deficiencies that required corrective action.

Legal and Technical Review. Contracting officers did not request a legal and technical review for a competitive contract valued at about $3.3 million ($659,000 per year x 5 option years) for diagnostic radiology services.

Fair and Reasonable Pricing. Contracting officers did not adequately conduct a cost or price analysis and market survey for a noncompetitive contract (value = $336,187) to remodel the surgery suite and the first floor outpatient area. A cost or price analysis and market survey were needed to determine if contract prices were fair and reasonable.

Excluded Vendors. Prior to awarding five contracts, contracting officers did not review the Excluded Party Listing System (EPLS) to ensure that the contracts were not awarded to vendors barred from doing business with the Federal Government.

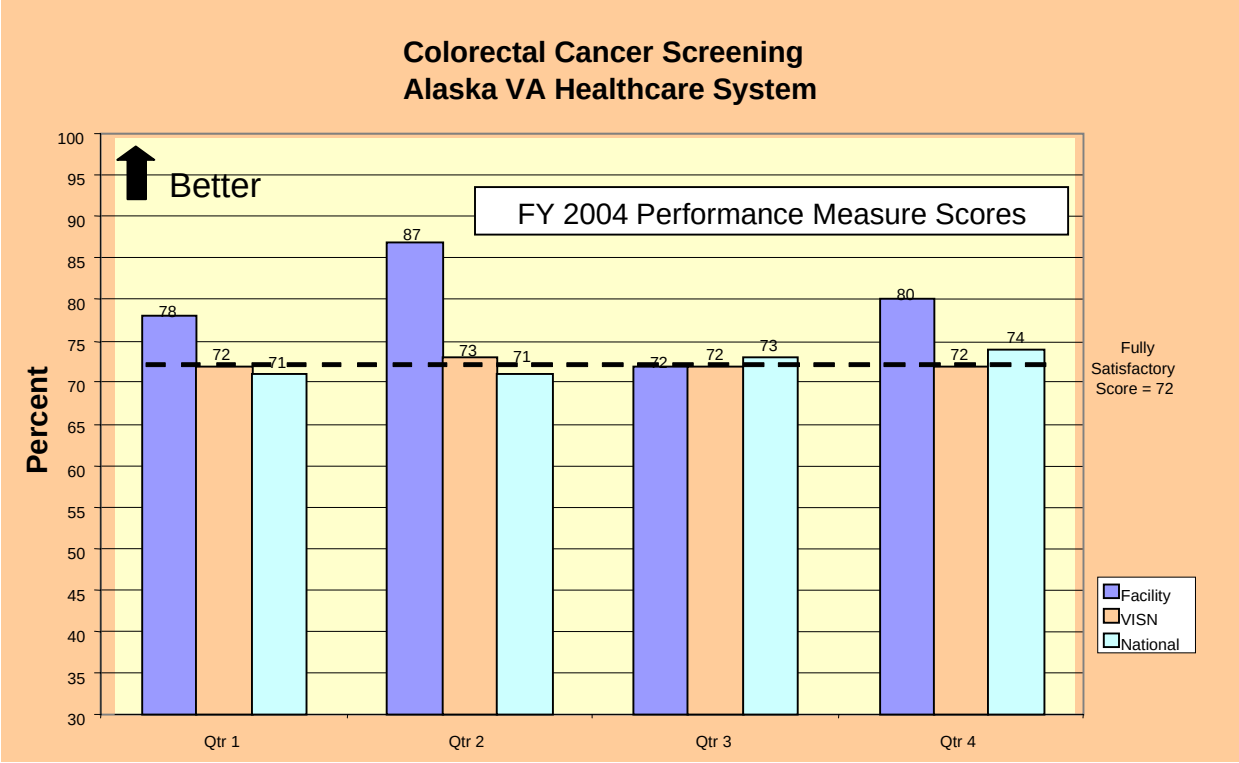
Recommendation 6. We recommended that the VISN Director ensure that the Healthcare System Director requires that for all future contracts contracting officers: (a)

request legal and technical reviews as required, (b) conduct cost or price analyses and market surveys, and (c) review the EPLS prior to contract award to determine if the vendor is barred from doing business with the Federal Government.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that as of August 2005, a plan had been implemented to use VISN 20 contract checklists and to mandate peer reviews prior to award of contracts. The improvement plans are acceptable, and we will follow up on the completion of the planned action.

Other Observation

Colorectal Cancer Management. The healthcare system met the VHA performance measure for colorectal cancer screening; provided timely gastroenterology, surgery, and hematology/oncology consultative and treatment services; promptly informed patients of diagnoses and treatment options; and developed coordinated interdisciplinary treatment plans. The VHA colorectal cancer screening performance measure assesses the percentage of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these actions in a judgment sample of 11 patients who were diagnosed with colorectal cancer during FY 2004. As the following chart shows, in FY 2004 the healthcare system's overall performance met or exceeded the VHA standard (72 percent) for patients screened within the prescribed timeframes.



In addition, all 11 patients in our sample were properly screened, diagnosed within 120 days, appropriately notified of their diagnoses, provided with interdisciplinary treatment plans, and received initial treatment within 45 days.

Appendix A

VISN 20 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2005

From: VISN 20 Acting Network Director (V20)

Subj: CAP Review of the Alaska VA Healthcare System, Anchorage, Alaska

To: Claire McDonald, Director, Seattle Audit Operations Division (52SE)

1. Attached are the completed Planned Improvement Actions for the six recommendations received for the Office of Inspector General from the recent completed Combined Assessment Program review of the Alaska VA Healthcare Sytem and Regional Office.

2. I appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

for Susan Yeager
Dennis M. Lewis, FACHE
Acting Network Director

Attachment

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2005

From: Director, Alaska VA Healthcare System (463/00)

Subj: CAP Review of the Alaska VA Healthcare System, Anchorage, Alaska

To: VISN20 Network Director (V20)

Attached are the completed Planned Improvement Actions for the six recommendations received for the Office of Inspector General from the recent completed Combined Assessment Program review.

Alex Spector

Attachment (2)

Alaska VA Healthcare System

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Physical Security – Pharmacy and Agent Cashier Security Should Be Improved

Recommendation 1. We recommend the VISN Director ensure the Healthcare System Director coordinates with VHA and VA officials to ensure the pharmacy wall and exterior windows and the agent cashier wall meet VA security standards.

Concur with recommended improvement actions

Planned Action:

The Facility will pursue waivers from VACO Police & Security and the appropriate VACO Program Officials (Pharmacy & Fiscal) that will allow the Facility to remain operational in its current state until the new facility is opened in early CY09. The new VA-owned facility will be constructed to meet all VA Physical Security requirements in accordance with VA Handbook 0730 and VHA Program Guide PG-18-3.

In the event that the waiver process is unsuccessful, the Facility has programmed FY06 NRM Project 463-06-100, Correct Physical Security Deficiencies, to address the identified issues. Since the landlord has previously stated that concrete masonry construction is not an option within the facility, we will correct the Pharmacy and Agent Cashier wall deficiencies with a Class III ballistic, modular fiberglass panel system, as permitted by VHA Program Guide PG-18-3. Target Completion Date: 4/28/2006.

2. Security and Law Enforcement – VA Police Officers Who are Trained and Qualified Should Be Armed

Recommendation 2. We recommend the VISN Director ensure the Healthcare System Director immediately implement the recommendation of the VA Office of Security and Law Enforcement to arm all VA police officers who are trained and qualified.

Concur with recommended improvement actions

Planned Action:

As of August 22, 2005, all VA Police Officers have been trained, certified, issued, and carry firearms.

3. Medical Care Collections Fund – Fee-Basis Insurance Billing Procedures Should Be Strengthened

Recommendation 3: We recommend the VISN Director ensure the Healthcare System Director requires MCCF staff begin billing insurance carriers for qualified home health services.

Concur with recommended improvement actions

Planned Action:

The Directors have approved the hiring of additional staff in MCCF to enable the section to bill areas not previously billed by the section. It is expected in the near future that these positions will be filled and billing of Home Health insurance to insurance carriers for treatment given to veterans will be implemented. We will continue to monitor this process. Target date for full compliance December 31, 2005.

4. Supply Inventory Management – Excess Medical Supply Inventory Should Be Reduced and Controls Improved

Recommendation 4. We recommend the VISN Director ensure the Healthcare System Director requires SPD staff to (a) keep GIP inventory records current by promptly and accurately posting inventory transactions and (b) monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory.

Concur with recommended improvement actions

Planned Action:

Decrease in inventory was performed from July 22, 2005 through August 5, 2005. There are currently 557 items in stock. 488 items are showing greater than 30 days stock on hand. This makes our percentage of over 30 days stock on hand at 87.61% The levels have been assessed and it is determined that of the 488 items, 120 are at the quantity on one and 74 items are at the quantity of two (the least we can go in most cases). Further assessment of the remaining found 204 items at the

lowest level of purchase, such as a case of 20, even if we use two a month. This leaves 80 items that will be adjusted further, providing the lesser amounts will meet contract minimum order amount. Of these 80 items, 31 items adjusted to the lowest level of purchase would still be over 30-days stock on hand. This facility uses the same items as the larger facilities, only in very small quantities. We must have these items on hand to keep functioning in patient care, even if we end up with 73.25% greater than 30-days stock on hand. See above synopsis of Days Stock on Hand Report ran August 29, 2005 (hard copy to be forwarded). A wall to wall inventory was conducted August 6, 2005 to establish an accurate inventory. SPD technicians were given an in-service covering; Handbook 1761.2 3a; SPD Level 1 Training – Module 9, Inventory Management; Materiel Handlers Training Guide 3-13 Inventory Procedures. Most remaining items were removed from the warehouse and is currently being stored in SPD to facilitate posting of all receipts and issues. The next wall to wall inventory will be October 29, 2005 to monitor accuracy.

5. Government Purchase Card Program – Administrative Oversight Should Be Strengthened

Recommendation 5. We recommend the VISN Director ensure the Healthcare System Director requires additional training for the PCC and all cardholders and approving officials on following proper exit procedures and purchase card policies.

Concur with recommended improvement actions

Planned Action:

An addition to the local policy, *Government Wide Credit Card*, dated June 2005, under "Exit Procedures for Cardholders," "Approving Officials Responsibilities," and "AOPC Responsibilities" has been added: "It should be understood that under no circumstances will a former employee's purchase card be reactivated to process outstanding purchases received after the employee has departed." An electronic training aid is being developed addressing the proper exit procedures for cardholders and approving officials. This will be sent to all cardholders and approving officials with a mandatory response, to ensure compliance with proper procedures. This area will be added to all bi-annual mandatory training. The exit procedures will be incorporated into the training of all new purchase cardholders and new approving officials. We will continue to monitor these processes. Target date for compliance: October 15, 2005.

6. Service Contracts – Documentation of the Contract Award Process Should Be Strengthened

Recommendation 6. We recommend the VISN Director ensure the Healthcare System Director require all future contracts contracting officers: (a) request legal and technical reviews as required, (b) conduct cost of price analyses and market surveys, and (c) review the EPLS prior to contract award to determine if the vendor is barred from doing business with the Federal Government.

Concur with recommended improvement actions

Planned Action:

The Alaska VA Healthcare System and Regional Office has implemented the use of VISN 20 Contract format and checklists. This will ensure that each requirement listed above will be reviewed with the formation of each contract to determine if the requirement is applicable for the transaction. The peer review on this checklist was optional; this facility will immediately be implementing mandatory peer review prior to award.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Improve procedures to bill insurance carriers for fee-basis home health care services.	$123,200
4	Reduce excess medical supply inventory.	23,802
	Total	$147,002

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald (206) 220-6654
Acknowledgments	Melinda Toom Daisy Arugay Julie Watrous Gary Abe Randall Alley James Eckrich Theresa Kwiecinski Ron Stucky Orlando Velasquez Wilma Wong

Appendix E

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