Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center West Palm Beach, Florida

Report No. 05-02813-32 **December 6, 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 June 6–10, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center West Palm Beach, FL. 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 provided 7 fraud and integrity awareness briefings to 367 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 8.

Results of Review

The CAP review covered 12 operational activities. The medical center complied with selected standards in the following seven activities:

- Administrative Boards of Investigation
- Colorectal Cancer Screening
- Contract Administration
- Controls Over Prescription Drugs
- Laboratory and Radiology Timeliness
- Part-Time Physician Time and Attendance
- Quality Management

Based on our review, we determined that QM's comprehensive web page was an organizational strength.

We identified five activities that needed management attention. To improve operations, the following recommendations were made:

- Improve testing of defibrillators.
- Improve controls over environment of care issues.
- Improve controls over supply inventory management.
- Improve controls over the Government Purchase Card Program.
- Improve procedures for recovering health care costs for the Medical Care Collections Fund (MCCF).

This report was prepared under the direction of Mr. James R. Hudson, Director, and Mr. Floyd C. Dembo, CAP Review Coordinator, Atlanta Audit Operations Division.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 11–17, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is a large tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community-based outpatient clinics located in Boca Raton, Stuart, Delray Beach, Fort Pierce, Okeechobee, and Vero Beach, FL. The medical center is part of VISN 8 and serves a veteran population of about 202,200 in a primary service area that includes 7 counties in southeastern Florida.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 132 hospital beds, 98 nursing home beds, a 17-bed Blind Rehabilitation Center, and a Homeless Veterans Service Program. The medical center also has sharing agreements with the JFK Medical Center for emergency cardiology services and the Department of Defense health care system for active duty personnel stationed at the Naval Undersea Warfare Center Detachment of the Atlantic Undersea Test and Evaluation Center.

Affiliations and Research. The medical center is affiliated with the University of Miami, the University of Florida, the Cleveland Clinic Florida, and the Nova Southeastern University School of Medicine and supports 10 medical and dental residents in graduate training programs. The medical center also has affiliations with over 150 programs of nursing and allied health professions. The medical center does not have any research projects.

Resources. In fiscal year (FY) 2004, medical care expenditures totaled $215 million. The FY 2005 medical care budget is $234 million, an 8.8 percent increase over FY 2004 expenditures. FY 2004 staffing totaled 1,790 full-time equivalent employees (FTE), including 162 physician FTE and 554 nursing FTE.

Workload. In FY 2004, the medical center treated 70,846 unique patients and provided 41,837 days of inpatient care and 30,570 days of VA nursing home care. The inpatient care workload totaled 5,863 discharges, and the average daily census, including nursing home patients, was 198. The outpatient workload was 527,404.

Objectives and Scope of the CAP Review

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

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on all recommendations from our previous CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center West Palm Beach, Florida*, Report No. 02-01273-55, February 3, 2003).

The review covered medical center operations for FY 2004 and FY 2005 through June 10, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following 12 activities:

Administrative Boards of Investigation	Government Purchase Card Program
Colorectal Cancer Screening	Laboratory and Radiology Timeliness
Contract Administration	Medical Care Collections Fund
Controls Over Prescription Drugs	Part-Time Physician Time and Attendance
Defibrillators	Quality Management
Environment of Care	Supply Inventory Management

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and quality of care. We made electronic survey questionnaires available to all medical center employees, and 73 employees responded. We also interviewed 30 patients during the review. The survey results were provided to medical center management.

During this review, we also presented 7 fraud and integrity awareness briefings to 367 medical center employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

An activity that was particularly noteworthy is recognized in the Organizational Strength section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–10). For these activities, we made recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Organizational Strength or Opportunities for Improvement sections, there were no reportable conditions.

Results of Review

Organizational Strength

Quality Management – Educational Web Page Included Resource Links

The Quality Manager developed a comprehensive web page that provided medical center staff easy access to educational resources and QM materials. The web page included links to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities electronic manuals, as well as patient safety and risk management information, performance indicators and measures, a description of the medical center's performance improvement program and reporting formats, patient and employee satisfaction information, JCAHO functional team activities and tracer updates, and clinical references. This web page is a valuable tool that employees accessed 348 times in the 2 months that it had been online.

Opportunities for Improvement

Defibrillators – Testing of Defibrillators Needed Improvement

Condition Needing Improvement. Nurses documented that they checked defibrillators daily in the Medical Intensive Care Unit (MICU), the Cardiac Catheterization Laboratory (Cath Lab), and Nursing Home Care Units (NHCU) L and J as required by medical center policy. However, paper test strips in the defibrillators did not always match the check sheets.

Designated employees are required by medical center policy to complete comprehensive checks of emergency crash carts and cardiac defibrillators each day. Emergency crash cart/defibrillator check sheets showed that staff checked the defibrillators daily from June 1–7, 2005. However, on the day of our review (June 7, 2005) the paper test strips in the defibrillators showed gaps between test dates and in some cases the test strips did not match the check sheets. For example, the Cath Lab's check sheet showed one of its defibrillators was tested on June 4 (a Saturday), a day the Cath Lab was closed. The test strip for the Cath Lab's other defibrillator showed no test on June 6. In NHCU J and NHCU L, the test strips showed no testing for June 5.

Defibrillators are life-saving equipment that must be maintained in operational order at all times. Untested defibrillators could be malfunctioning, which could result in negative patient outcomes.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) defibrillator testing policies and

procedures are clarified and employees are trained accordingly and (b) procedures to monitor defibrillator testing are established.

The VISN 8 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that a message clarifying current policies and procedures has been sent to all staff that checks defibrillators. To ensure monitoring of defibrillator testing, each Unit Facilitator is responsible for checking the defibrillators daily, documenting the tests on check sheets, and maintaining the test strips. We will follow up on the planned actions until they are completed.

Environment of Care – Cleanliness and Safety Concerns Needed Improvement

Condition Needing Improvement. We inspected wards 6A, 3C, the NHCU, the Dialysis Unit, the emergency room, and public areas, and generally found the medical center to be clean. However, several issues needed management attention.

Terminal Cleaning. Two of three patient rooms we inspected to assess the quality of terminal cleaning (cleaning a room before it is assigned to a new patient) needed additional cleaning. We found layers of dust on the bed frames, over-bed lights, and furniture. One mesh chair on ward 6A had stains. When a patient is discharged, all furniture and equipment used by the patient must be thoroughly cleaned to prevent the possibility of infections being transmitted to the next patient. Terminal cleaning should include high and low dusting and antiseptic wipe downs of furniture and equipment. Inadequate terminal cleaning can lead to nosocomial infections and increased patient lengths of stays.

Dialysis Unit Infection Control and Cleanliness. Dialysis nurses used a towel wrapped around a portable carbon dioxide tank to control water leakage. The towel was not changed between patients, which presented a potential infection control problem. Portable dialysis is provided for patients in intensive care units if needed. The nurse manager directed dialysis nurses to change the towels between patient treatments when using the portable equipment.

The Dialysis Unit storeroom floors were littered and dusty. Environmental Management Service (EMS) managers had the storeroom floors cleaned, posted a schedule for cleaning and monitoring, and took administrative action against the responsible housekeeping supervisor.

Clinical Alarms Setting Checklist. During our environmental inspection, we found an incomplete Clinical Alarms Setting Checklist on one unit, and followed up by reviewing checklists on nine other units. In 3 of 10 units, checklists for June 1–7, 2005, were not consistently completed.

- NHCU-L staff did not complete any daily checklists for feeding pumps and the Wander Guard system, or the weekly checklist for emergency and patient call bells and bed alarms.
- NHCU-J staff did not complete the daily checklists for intravenous/patient controlled analgesia pumps, feeding pumps, the Wander Guard system, or ventilators on June 4.
- Post Anesthesia Care Unit staff did not complete the daily checklists for cardiac monitors, intravenous pumps, feeding pumps, or ventilators on June 2 or June 3.

Because of the absence of documentation on the Clinical Alarms Setting Checklists, we were unable to confirm whether testing of clinical alarms was completed. Without appropriate testing, staff could not be assured that clinical alarms were operable. If not audible or functioning correctly, a clinical alarm could fail to alert staff to a patient's need for clinical attention in a timely manner and could result in a negative patient outcome.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) terminal cleaning of patient rooms, (b) appropriate infection control practices by dialysis nurses, and (c) consistent clinical alarm testing.

The VISN 8 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that letters of counseling which outline processes for terminal cleaning and daily area checks were sent to EMS managers. To ensure appropriate infection control practices, the dialysis nurses have been instructed to change towels used on carbon dioxide tanks between patients. To ensure consistent documentation of clinical alarm testing, the Unit Facilitators will ensure that alarms are tested and that alarm check lists are completed in accordance with local policy. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed Improvement

Condition Needing Improvement. Acquisition and Materiel Management Service (A&MMS) staff did not effectively use the Generic Inventory Package (GIP) system to manage inventory levels.

Inaccurate Inventory Balances. We found that GIP inventory records did not accurately reflect inventory balances. A&MMS established 26 inventory control points (ICP). We reviewed a judgment sample of 120 stock items (value = $503,169) from 6 of the largest ICPs, and found that inventory records were not accurate for 71 items (59 percent). Our physical count of the 71 items found that 47 items were overstated by $82,344 (less stock

on hand than recorded in GIP) and 24 items were understated by $49,932 (more stock on hand than recorded in GIP). The results of the counts were as follows:

ICP	Items Counted	Number of Incorrect Balances	Percent Incorrect	GIP Inventory Value	Adjusted Value	Variance
Carpenter Shop	20	15	75%	$ 67,449	$ 64,145	($ 3,304)
Common Items	20	16	80%	36,709	30,376	(6,333)
Electric Shop	20	11	55%	45,906	45,296	(610)
Energy Center	20	3	15%	209,031	222,969	13,938
Imaging Service	20	7	35%	71,307	58,536	(12,771)
Operating Room	20	19	95%	72,767	49,435	(23,332)
Total	**120**	**71**	**59%**	**$503,169**	**$470,757**	**($32,412)**

VA policy requires a minimum acceptable accuracy rate of 90 percent for inventories.

Inadequate Usage Data. As of May 31, 2005, the medical center had 8,996 inventory items in GIP, valued at about $2 million. GIP contained no usage data for 6,568 (73 percent) of the 8,996 inventory items. Engineering Service just began implementing GIP prior to our review, and as a result, almost 90 percent of the items without usage data were in Engineering Service ICPs. For the 2,428 items with usage data in GIP, 2,146 items (89 percent) exceeded a 30-day supply by about $446,000. Because of the large discrepancies between the GIP inventory records and our physical count, and the large number of items without usage data, we could not determine the total amount of stock on hand that actually exceeded VHA's 30-day supply requirement. Once GIP inventory records have been corrected and ICP stock usage data has been entered into GIP, A&MMS staff should reduce the amount of stock on hand to the 30-day supply level.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) GIP inventory records are accurate, (b) ICP stock usage data is entered into GIP, and (c) stock levels are reduced to a 30-day supply level.

The VISN 8 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that in order to ensure a match of stock on hand to the balances listed in GIP, the inventory is scanned, receipts and issues are posted on a daily basis, all issues are pulled, and all stock received is placed on the shelves. In addition, all ICPs are scanned to capture stock usage at a minimum of once a month and areas that have critical supplies or heavy use items are scanned more often. All recurring use medical supply items will be managed utilizing a level of 30-day supply of stock on hand. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Needed Improvement

Condition Needing Improvement. The medical center needed to improve controls over the Government Purchase Card Program. During the 19-month period ending April 30, 2005, cardholders completed 50,796 transactions totaling about $29.7 million. The following conditions needed improvement.

Segregation of Duties. The Fiscal Officer performed several purchase card functions that resulted in inadequate segregation of duties. The Fiscal Officer was both the medical center's billing officer for the Government Purchase Card Program and the approving official for 21 (32 percent) of the 65 cardholders. VA policy states that the billing officer cannot also be a cardholder or an approving official. Medical center managers reassigned the billing officer duties to another staff member during our review.

Prohibited Purchases. Four cardholders used their Government purchase cards to purchase airline tickets for employee travel. VHA policy prohibits the use of purchase cards to procure employee travel. During the period October 1, 2003, through April 30, 2005, the cardholders made 16 charges totaling about $7,500 for travel by 7 employees of the Physical Medicine and Rehabilitation Service. During our review, the purchase card coordinator issued instructions to all cardholders not to use purchase cards to procure employee travel.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) segregation of duties between the billing officer, approving officials, and cardholders is maintained and (b) cardholders do not use purchase cards to procure employee travel.

The VISN 8 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that to ensure segregation of duties, a new billing official has been appointed. To ensure that cardholders do not use purchase cards to procure employee travel, the services and cardholders responsible for such actions have been instructed to discontinue doing so. We will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries

Condition Needing Improvement. The medical center's MCCF program collected almost $25 million in FY 2004, nearly 99 percent of its $25.3 million goal. Additional recoveries from insurance carriers could be made by ensuring that bills of collection are issued when sufficient documentation is available, and by improving follow-up with medical care providers to obtain documentation needed to issue bills of collection.

The "Reasons Not Billable Report" for the quarter ending December 31, 2004, listed only 50 episodes of care totaling $63,000 that were determined to be not billable because of insufficient or no documentation. Our review of all 50 episodes of care found 26 (52 percent) missed billing opportunities. Nineteen of the 26 episodes of care either had necessary documentation or the necessary documentation was obtained after the initial coding, but bills of collection were not issued. MCCF management agreed to issue bills of collection totaling about $20,300 for these 19 episodes of care as a result of our review. Seven of the 26 episodes of care totaling about $1,300 did not have necessary documentation from the medical care providers for billing purposes and MCCF staff did not follow-up with providers to obtain documentation needed for billing. The remaining 24 episodes of care were either billed prior to our review, not covered by insurance, or were not billable.

If providers would have appropriately documented all medical care provided, an additional $21,600 ($20,300 + $1,300) could have been billed for the encounters in the "Reasons Not Billable Report." Based on the medical center's average collection rate of 46.7 percent, an additional $10,087 could have been collected ($21,600 x 0.467 = $10,087).

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that MCCF staff (a) issue bills of collection for episodes of care sufficiently supported by medical record documentation and (b) follow-up with medical care providers to obtain needed documentation of the care provided.

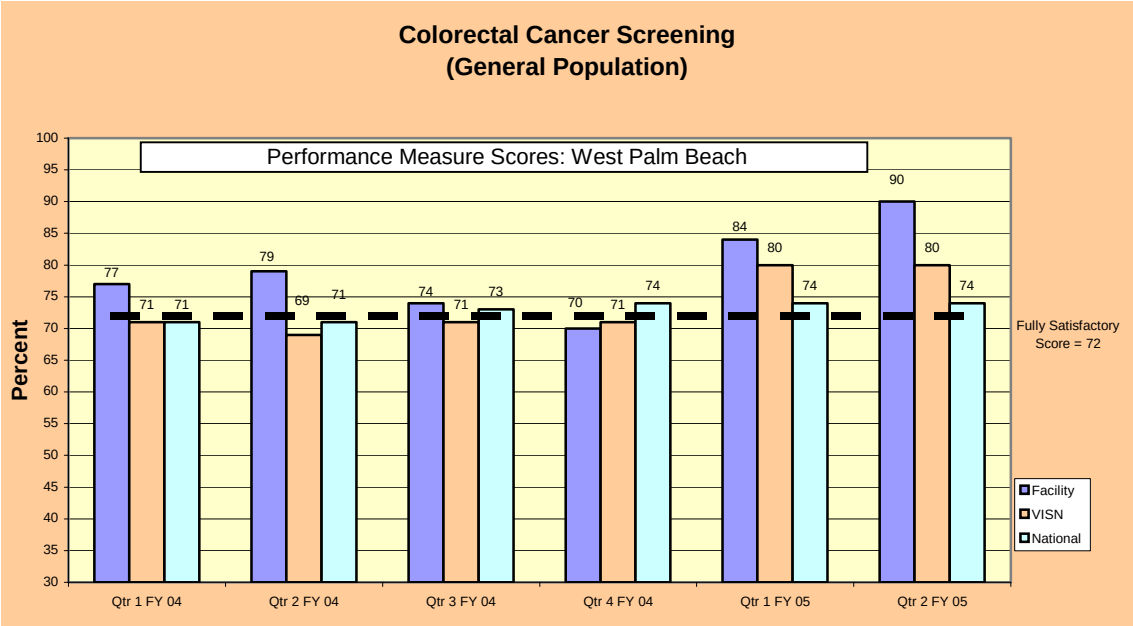
The VISN 8 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the "Reasons Not Billable Report" will be reviewed each month by the Compliance Officer and bills will be submitted for all billable episodes of care sufficiently supported by medical evidence. In addition, documentation of care provided will be obtained from appropriate providers to correct any missed billing opportunities. We will follow up on the planned actions until they are completed.

Other Observation

Colorectal Cancer Management - Patients are Managed Appropriately

The medical center met the VHA performance measure for colorectal cancer (CRC) screening, provided timely Surgery and Hematology/Oncology consultative and treatment services, informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans. All of these elements are essential to appropriate management of CRC patients and optimal patient outcomes.

The following table illustrates the facility's CRC screening performance.



We assessed a random sample of 11 patients diagnosed with CRC during FY 2004. Our review found that 8 (73 percent) of 11 patients received timely GI consultations and 9 (82 percent) of 11 received timely diagnoses. In 2004, managers identified problems with the management of CRC patients and chartered a process action team. As a result, the process for prioritizing consultation requests for scheduling was modified. Managers told us that a clinician reviews all consultation requests and that a service agreement, which defines the conditions for referral between primary care and GI, was implemented in 2005. The medical center is currently meeting the demand for endoscopy procedures.

Appendix A

VISN Director's Comments

Department of Veterans Affairs **Memorandum**

Date: September 6, 2005

From: Director, Veterans Integrated Service Network 8 (10N8)

Subject: **VA Medical Center West Palm Beach, Florida**

To: Director, Management Review and Administrative Service (10B5)

1. Thank you for the opportunity to review the VA Medical Center West Palm Beach Combined Assessment Program Review Draft Report.

2. The VISN concurs with all of the recommendations made by the Office of Inspector General and agrees with the actions taken by the medical center to improve processes at the facility.

3. If you have further questions, please contact Karen Maudlin at (727) 319-1063.

George H. Gray, Jr.

George H. Gray, Jr.

Network Director, VISN 8

Appendix B

Medical Center Director's Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2005

From: Director, VA Medical Center West Palm Beach, Florida (548/00)

Subject: **VA Medical Center West Palm Beach, Florida**

To: Director, Veterans Integrated Service Network 8 (10N8)

Thank you for the opportunity to review the draft report for West Palm Beach VA Medical Center. We appreciate your input in regard to the care we provide veterans.

If you have any questions, please contact Kathy McGrath-Burger at (561) 422-7355.

(original signed by:)
Edward H. Seiler

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) defibrillator testing policies and procedures are clarified, and employees are trained accordingly and (b) procedures to monitor defibrillator testing are established to ensure compliance.

Concur **Target Completion Date:** 8/05

(a) A message clarifying current policies and procedures has been sent to all staff that checks defibrillators. Nurse managers have ensured that all staff understands current policy.

(b) To ensure monitoring of defibrillator testing, the Unit Facilitator is responsible to check the defibrillator daily, document on check sheet, and maintain test strip. Nurse Managers will review the check sheets on a monthly basis to ensure that test strips are printed daily and maintained with monthly test log. Nursing representative will check the code carts and check sheets during weekly environmental rounds and ask staff about their knowledge of defibrillator checks. Compliance will be reported to Nursing Professional Practice Council on a monthly basis. Actions will be taken as necessary based on the findings of the monitors.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) terminal cleaning of patient rooms, (b) appropriate infection control practices by dialysis nurses, and (c) consistent clinical alarm testing with documentation

Concur **Target Completion Date:** 8/05

(a) Room and chair were terminally cleaned at time of survey. Letters of counseling which outlined process for terminal cleaning and daily area checks were sent to EMS supervisors. Letters were signed and dated by supervisors and returned to EMS office for filing. A daily cleanliness inspection/check sheet for each area which notes the conditions and where improvements are required is checked and signed daily by the supervisor responsible for the area. Deficiencies are brought to the attention of the EMS Supervisor.

(b) Dialysis storage room was terminally cleaned at time of CAP survey. A daily cleanliness inspection/check sheet for each area which notes the conditions and where improvements are required is checked and signed daily by the responsible supervisor. Deficiencies in any area are brought to the attention of the EMS Supervisor. To ensure appropriate infection control practices by the dialysis nurses, the nurses have been instructed to change towels used on carbon dioxide tanks between each patient. This will be monitored via random checks by the nurse manager.

(c) To ensure consistent documentation of clinical alarm testing, the Unit Facilitators will ensure that alarms are tested and that alarm check lists are completed per policy. Nurse Managers will review the alarm check lists on a monthly basis to ensure that all clinical alarms are checked according to policy. Additionally, check lists will be reviewed by the Nursing representative during weekly environmental rounds. Findings will be reported monthly to NPPC and to the Nurse Executive.

Recommended Improvement Action 3. We recommended the VISN Director ensure that the Medical Center Director requires that: (a) GIP inventory records contain accurate inventory balances, (b) ICP stock usage data is entered in GIP, and (c) stock levels are reduced to a 30-day supply level.

Concur **Target Completion Date:** 8/05

(a) The VISN 8 GIP Review Team had return visit to WPB on August 17th, 2005 to evaluate progress towards GIP implementation and had no negative findings. In order to ensure a match of stock on hand on the shelf to the balance listed in the GIP report, the inventory is scanned, receipts and issues posted on a daily basis, all issues pulled, and all stock received placed on the shelf. This is done on a continuing basis and this procedure assures an accurate balance of stock on hand to match GIP reports. Reports are printed and reviewed by Materiel Management Supervisors on a monthly basis to validate the above procedures were accomplished. In addition to the above, an audit of inventory balances will be completed on a quarterly basis. Supplies are continuously being received and issued based on patient workload. It would need to be verified that all of the above steps were completed on each inventory primary before a physical count could be expected to match GIP Reports of balance on hand. This is because stock can be removed and used between inventory scans.

(b) All Primary inventory points are scanned to capture usage at a minimum of once a month. Some areas that have critical supplies or heavy use items are scanned more often. At the time of the OIG audit, this facility had just completed entering the Engineering supplies into the GIP; this was approximately 6,000 line items. These items had been scanned for one month and usage had only been captured on the items used during that one month period. As stock is used by the departments, it will be captured in the GIP during the monthly inventory scan. There are items in Engineering Service that are considered emergency repair parts that may not have usage for long periods of time. This is also the situation in some areas such as OR, Imaging, Cardiac Cath, etc., supplies are kept on hand for emergency situations, that must be available, but may not have frequent usage. All stock usage data will be captured and entered in the GIP at a minimum of once a month when the inventory is scanned.

(c) All recurring use medical supply items will be managed utilizing a level of 30-day supply of stock on hand. Some critical items must be kept on hand for emergency usage, i.e. OR and Cardiac Cath supplies that will not have frequent usage and the levels will show more that a 30-day supply of stock on hand. However, all Inventory Management Specialists (IMS) will receive training on use of the reports available in the GIP, such as the Days of Stock on Hand Report. The Chief, Materiel Management Division will review this report at least quarterly to assure the IMS are lowering levels to a 30-day supply of stock on hand. Service Chiefs will be sent copies of reports showing usage for supplies stocked in their areas with recommendations to delete items from stock that do not show usage.

Recommended Improvement Action 4. We recommended the VISN Director ensure that the Medical Center Director requires that (a) separation of duties between the billing officer, approving officials, and cardholders are maintained and (b) cardholders do not use purchase cards for employee travel.

Concur **Target Completion Date:** 8/05

(a) To ensure separation of duties between the billing officer, approving officials, and cardholders, a new Billing Official has been appointed. His responsibilities include verification of transactions/payments for the approving officials' certified statements.

(b) To ensure that cardholders do not use purchase cards for employee travel, Services and cardholders responsible for such actions have been informed via official memorandum of the inappropriateness and have been instructed to discontinue such actions. Employees attending veteran special events in the future are required to submit a formal travel request for approval through the Employee Education Service. 100% audits are currently being performed every quarter.

Recommended Improvement Action 5. We recommended the VISN Director ensure that the Medical Center Director requires that MCCF staff (a) issue bills of collection for episodes of care sufficiently supported by medical evidence and (b) follow-up with attending physicians to obtain needed documentation of the care provided.

Concur **Target Completion Date:** 8/05

(a) Bills are submitted timely and correctly for all billable episodes of care sufficiently supported by medical evidence. The "Reasons Not Billable" report will be run each month by the Compliance Officer. The episodes marked, "no documentation" or "insufficient documentation" will be reviewed jointly by the Revenue Officer, HIMS Chief, Chief MAS and Compliance Officer on a monthly basis. Any missed billing opportunities will be corrected once documentation has been coded, and new bills will be submitted as appropriate, as well as tracking and trending any common problems. Feedback will be provided to appropriate medical center staff on an ongoing basis to prevent future errors.

(b) Documentation of care provided will be obtained from appropriate providers to correct any missed billing opportunities. Feedback and training with attending physicians will be provided as a result of any identified trends and this will be done on an ongoing basis.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5a	Issue bills of collection for episodes of care sufficiently supported by medical record documentation.	$10,087

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	James R. Hudson, Director, Atlanta Audit Operations Division (404) 929-5921
Acknowledgments	Floyd C. Dembo, CGFM, Audit Manager (CAP Review Coordinator) Atlanta Audit Operations Division Victoria Coates, Director, Atlanta Office of Healthcare Inspections Christa Sisterhen, Deputy Director, Atlanta Office of Healthcare Inspections Ann Batson, Audit Team Leader Bertie Clarke, Healthcare Inspections Team Leader George Boyer Melissa Colyn Harvey Hittner Earl Key Tina Mitchell Toni Woodard Susan Zarter

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
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Director, Veterans Integrated Service Network 8 (10N8)
Director, VA Medical Center West Palm Beach, FL (548/00)

Non-VA Distribution

House Committee on Veterans' Affairs
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House Committee on Government Reform
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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mel Martinez, Bill Nelson
U.S. House of Representatives: Mark Foley, Alcee Hastings, Clay Shaw, Dave Weldon, Robert Wexler

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.