Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Tennessee Valley Healthcare System Nashville, Tennessee

Report No. 05-02298-65 **January 30, 2006**

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 Tennessee Valley Healthcare System. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 215 employees. The healthcare system is part of Veterans Integrated Service Network (VISN) 9.

Results of Review

This CAP review focused on 12 operational activities. The healthcare system complied with selected standards in the following four activities:

- Controlled Substances Accountability
- Environment of Care
- Government Purchase Card Program
- Laboratory Services

We identified eight activities that needed additional management attention. To improve operations, we made the following recommendations:

- Strengthen service contract controls by requesting preaward audits when required.
- Increase Medical Care Collections Fund (MCCF) collections by strengthening fee-basis billing procedures and improving the documentation of medical care and resident supervision.
- Improve the timeliness of colorectal cancer (CRC) diagnoses by reducing the time from Gastroenterology (GI) consultations to patient evaluations.
- Provide prompt magnetic resonance imaging (MRI) services.
- Strengthen the QM program by improving Root Cause Analyses (RCAs) and Healthcare Failure Mode Effects Analyses (HFMEAs) and by trending and analyzing performance improvement (PI) functions.
- Improve controls over timekeeping for part-time physicians by requiring that part-time physicians designate at least 25 percent of their total work hours as core hours, record their hours worked on subsidiary time sheets, and change their tours of duty only after written requests have been properly approved and processed through the Payroll Section.
- Strengthen supply inventory management by maintaining accurate supply records and reducing stock levels.

- Improve care and services by ensuring that healthcare system memorandums are up to date.

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

VISN 9 and Healthcare System Director Comments

The VISN 9 and Healthcare System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 13–24 for the full text of the Directors' comments.) The VISN and Healthcare System Directors did not agree with the estimated monetary benefits relating to service contracts because they believed contracting officers had negotiated prices that were below fair market value. In our opinion, since these contracts were not subject to an independent preaward review as required by Veterans Health Administration (VHA) policy, we do not believe the Directors presented a factual basis for disagreeing with our estimated monetary benefits. Absent a preaward review, we continue to maintain that our estimated monetary benefits remain reasonable. We will follow up on the implementation of planned improvement actions.

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

Introduction

Healthcare System Profile

Organization. The healthcare system consists of the Alvin C. York VA Medical Center located in Murfreesboro, TN, and the Nashville VA Medical Center located in Nashville, TN. Outpatient care is provided at nine community-based outpatient clinics located in Chattanooga, Clarksville, Cookeville, Dover, Knoxville, Tullahoma, and Vine Hill, TN; and Bowling Green and Fort Campbell, KY. The healthcare system is part of VISN 9 and serves a veteran population of about 423,000 residing in 89 counties in Georgia, Kentucky, Tennessee, and Virginia.

Programs. The healthcare system provides ambulatory, primary, and secondary care in acute medicine and surgery. It also provides specialized tertiary care, transplant services, spinal cord outpatient care, and a full range of extended care and mental health services. The healthcare system has 519 operating beds, including 185 nursing home beds.

Affiliations and Research. The healthcare system is affiliated with Meharry Medical College and the Vanderbilt University School of Medicine and supports 161.5 resident positions. In fiscal year (FY) 2004, the healthcare system had 251 research projects and a research budget of about $22.6 million. Important areas of research included cardiology, diabetes, endocrinology, molecular medicine, nephrology, oncology, and tuberculosis.

Resources. The healthcare system's medical care expenditures totaled $327 million in FY 2004. The FY 2005 medical care budget was $369 million. In FY 2004, the healthcare system had 2,464 full-time equivalent employees (FTE), which included 163.8 physician FTE and 513.2 nursing FTE.

Workload. The healthcare system treated 73,337 unique patients in FY 2004. The inpatient workload in FY 2004 totaled 9,297 discharges, and the average daily census, including nursing home patients, was 409. The outpatient workload totaled 523,990 visits in FY 2004.

Services for Military Personnel Returning from Iraq and Afghanistan. The healthcare system offers a comprehensive program of services to veterans returning from Iraq and Afghanistan. Each quarter, VISN 9 provides the healthcare system with a list of returning military personnel. The healthcare system mails letters to those personnel explaining the 2-year benefit period and inviting them to enroll for medical care. Military treatment facilities also refer returning military personnel to the healthcare system for evaluation and treatment. Healthcare system employees schedule medical examinations within 30 days and coordinate medical care and referrals to the Veterans Benefits Administration to establish entitlement for service-connected compensation and pension benefits. Through its outreach efforts, the healthcare system has contacted

approximately 6,000 returned military personnel and enrolled 644 military personnel for VA care.

Objectives and Scope of the CAP Review

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

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered healthcare system operations for FYs 2003, 2004, and 2005 through July 22, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Colorectal Cancer Management	Medical Care Collections Fund
Controlled Substances Accountability	Quality Management
Environment of Care	Radiology Services
Government Purchase Card Program	Service Contracts
Healthcare System Memorandums	Supply Inventory Management
Laboratory Services	Timekeeping for Part-Time Physicians

As part of the review, we interviewed 30 patients to survey patient satisfaction with the timeliness of service and the quality of care. The results were shared with healthcare system managers.

We also presented three fraud and integrity awareness training sessions. A total of 215 employees attended the training, which covered procedures for reporting suspected

criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Follow-Up on Prior CAP Review Recommendations

As part of this review, we also followed up on the recommendations resulting from our prior CAP review of the healthcare system (*Combined Assessment Program Review of the VA Tennessee Valley Healthcare System*, Report No. 01-00788-108, August 8, 2001). During this CAP review, we determined that the healthcare system continues to need improvement in the areas of MCCF, QM, timekeeping for part-time physicians, and supply inventory management.

Results of Review

Opportunities for Improvement

Service Contracts – Preaward Audits Needed To Be Requested

Condition Needing Improvement. The healthcare system needed to request preaward audits of service contracts when required. To evaluate contracting activities, we reviewed 4 noncompetitive and 12 competitive service contracts valued at about $43.1 million. Our review showed that contracting officers (COs) had appropriate warrant authorities, contract files were generally well organized, all required legal and technical reviews were done, and COs and contracting officers' technical representatives had received appropriate acquisition training. However, we identified one issue requiring management attention.

VHA policy requires that all noncompetitive contracts with affiliated medical schools valued at $500,000 or more (inclusive of option years) be sent to the OIG for preaward audits. The primary purpose of a preaward audit is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. Our review included four contracts awarded during FYs 2004 and 2005 with a total value of about $10.9 million that required preaward audits. However, the healthcare system did not request preaward audits for three of the four contracts. The total value of the three contracts was $7,554,000. This occurred because contracting managers incorrectly thought that the VA Office of Acquisition and Materiel Management would automatically request required preaward audits as part of its legal and technical reviews of the healthcare system's contracts and that the threshold for preaward audits only included the base year of a contract. We estimated that preaward audits would have resulted in cost savings of $983,531.[1]

Recommendation 1. We recommended the VISN Director ensure the Healthcare System Director requires that preaward audits by the OIG be requested when required.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that a process has been established to ensure that all required preaward audits are completed prior to contract award. The VISN and Healthcare System Directors did not agree with the estimated monetary benefits because they believed contracting officers had negotiated prices that were below fair market value. In our opinion, since these contracts were not subject to an independent preaward review as required by VHA policy, we do not believe the Directors presented a factual basis for disagreeing with our

[1] The OIG has determined that preaward audits have resulted in potential average savings of 21 percent of the total value of proposed contract prices. The OIG has also determined that 62 percent of the potential cost savings has been sustained during contract negotiations. Applying these percentages to the total estimated value of the contracts ($7,554,000 x 21 percent x 62 percent) resulted in estimated cost savings of $983,531.

estimated monetary benefits. Absent a preaward review, we continue to maintain that our estimated monetary benefits remain reasonable. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Fee-Basis Billing Procedures and Clinical Documentation Needed Improvement

Condition Needing Improvement. The healthcare system could increase MCCF collections by strengthening billing procedures for fee-basis care and improving documentation of medical care and resident supervision. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. A consolidated Customer Accounts Center performs the cost recovery functions for the medical facilities in VISN 9. During FY 2004, the healthcare system collected $20.9 million, which was 81 percent of its collection goal of $25.9 million. The healthcare system collected $19.5 million during the first 9 months of FY 2005, which was 80 percent of its FY 2005 collection goal of $24.5 million.

Fee-Basis Billings. From October through December 2004, the healthcare system paid 6,902 fee-basis claims totaling $1,081,653 to non-VA clinicians for the care of veterans with health insurance. To determine if the healthcare system had billed the insurance carriers for this care, we reviewed a random sample of 43 fee-basis claims totaling $93,915. Twenty-one of the claims were not billable to the insurance carriers because the fee-basis care was for service-connected conditions, the veterans did not have insurance coverage on the dates of care, or the care provided was not billable under the terms of the insurance plans. The remaining 22 fee-basis claims totaling $76,861 should have been billed. These missed billing opportunities occurred primarily because Fee-Basis Unit and Social Work Service personnel did not provide copies of paid invoices, which were needed to bill the insurance carriers, to the Customer Accounts Center.

Medical Record Documentation. Medical care providers needed to improve the documentation of care. VHA policy requires medical care providers to enter documentation into medical records at the time of each encounter so that MCCF personnel can bill insurers for the care provided. The policy also requires that medical records clearly demonstrate attending physicians' supervision of residents in each type of resident-patient encounter. The "Reasons Not Billable Report" for the 3-month period ending December 31, 2004, listed 455 potentially billable cases totaling $68,633 that were not billed for 1 of 3 reasons—insufficient documentation, no documentation, or non-billable provider (care provided by a resident physician). We reviewed a random sample of 50 potentially billable cases and found 43 (86 percent) missed billing opportunities totaling $6,198 (an average of $144.14 per missed billing opportunity) that could have been billed if medical documentation had been complete. For example, Customer Accounts Center personnel did not issue bills for 26 of the missed billing opportunities because the veterans' medical records were missing the required medical

documentation. Twelve additional missed billing opportunities occurred because attending physicians' supervision of residents was not adequately documented in the veterans' medical records. Based on our sample results, we estimated that 391 (455 potentially billable cases x 86 percent) additional bills totaling $56,359 (391 estimated billable cases x $144.14) could have been issued.

Potential Collections. Improved billing procedures for fee-basis care and better clinical documentation would enhance revenue collections. We estimated that additional billings totaling $133,220 ($76,861 + $56,359) could have been issued. Based on the healthcare system's FY 2004 collection rate of 26 percent, MCCF personnel could have increased collections by $34,637 ($133,220 x 26 percent). As a result of our review, MCCF personnel issued 30 bills totaling $72,927 and were working to issue additional bills for the remaining missed billing opportunities.

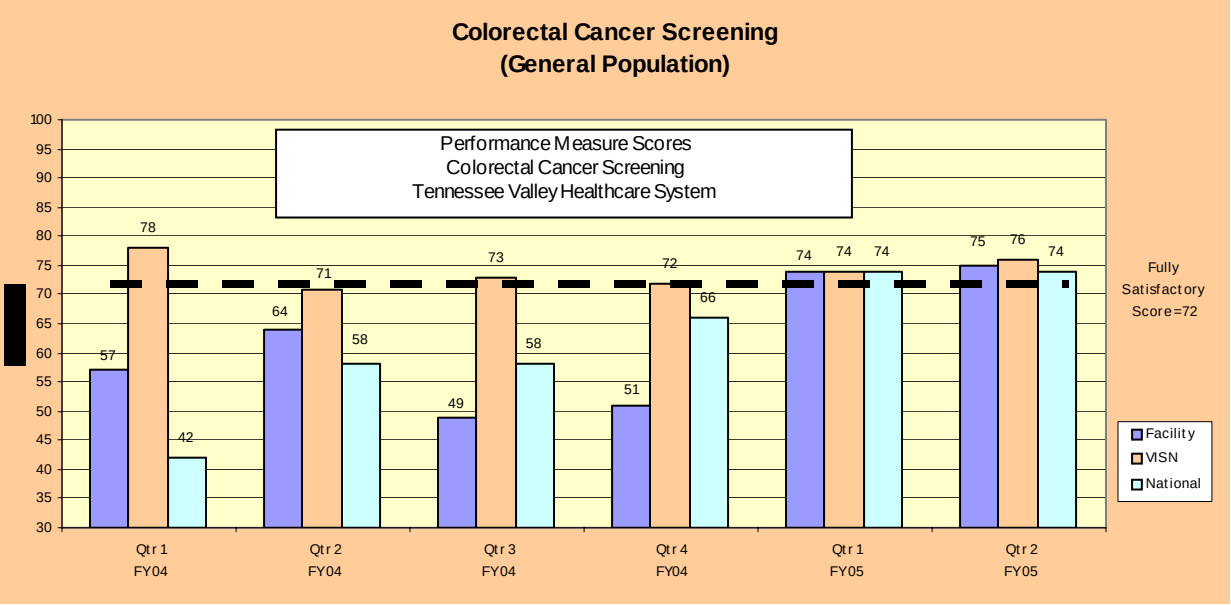
Recommendation 2. We recommended that the VISN Director ensure the Healthcare System Director requires that: (a) Fee-Basis Unit and Social Work Service personnel promptly forward the documentation needed for billing insurance carriers to the Customer Accounts Center, (b) medical care providers adequately document resident supervision and the care provided in veterans' medical records, and (c) all billable fee-basis and VA care be identified and billed.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that a new process was established in July 2005 to ensure that all required documentation needed for billing insurance carriers is promptly forwarded to the Customer Accounts Center. Clinical staff will use templates to ensure all resident supervision documentation requirements are met. Service chiefs and the Compliance Committee are monitoring compliance. In addition, the healthcare system will use Decision Support System reports to monitor all billing opportunities to ensure that all billable care is identified and billed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Colorectal Cancer Management – Gastroenterology Consultation Waiting Times Needed To Be Reduced

Condition Needing Improvement. Clinicians needed to improve the timeliness of CRC diagnosis by reducing the time from GI consultation to patient evaluation. The healthcare system provided appropriate CRC screening to all but 1 of the patients in our sample of 10, provided timely Surgery and Hematology/Oncology consultative services, developed coordinated interdisciplinary treatment plans, and promptly informed patients of diagnoses and treatment options. However, the lack of responses to initial consultation requests and scheduling difficulties caused significant delays in performing diagnostic GI procedures.

The table on the following page illustrates the healthcare system's performance in FY 2004 and the first 2 quarters of FY 2005 for CRC screening.



We reviewed a random sample of 10 CRC cases diagnosed in FY 2004 and found that in 4 cases significant delays (113 to 813 days) occurred between presentation with symptoms and CRC diagnosis. In one case, GI providers did not respond to the initial consultation request, and the consultation was administratively closed 19 months later. The primary care provider initiated a new request, and the patient was evaluated the following month—813 days after the initial request for a GI consultation. The other three patients waited between 90 and 231 days due to scheduling errors or patient appointment notification problems.

Managers have addressed these issues, and the healthcare system met VHA performance measures for CRC screening and GI waiting times for the first 2 quarters of FY 2005. The current GI Service Agreement requires GI staff to triage (prioritize for scheduling purposes) all routine consultation requests within 5 working days and to schedule appointments within 5 days of triage. The goal for completion of a routine symptom-based referral is 12 weeks. GI Service has requested an additional FTE (an Advanced Practice Nurse) to aid in managing the outpatient consultations.

Recommendation 3. We recommended that the VISN Director ensure the Healthcare System Director requires that the healthcare system comply with the timeliness standards established in the GI Service Agreement.

The VISN and Healthcare System Directors agreed with the finding and recommendation and reported that the healthcare system has requested an additional GI Fellow to provide

same day consultation and to monitor timeliness. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Radiology Service – Magnetic Resonance Imaging Was Not Completed Timely

Condition Needing Improvement. From June 1–30, 2005, the average waiting time (72.3 days) to schedule and complete MRIs exceeded healthcare system and VHA timeliness standards. The healthcare system's policy, which expired in March 2005, indicated that Imaging Service would put forth every effort to provide prompt imaging services, consultations, and interpretations with an average turn-around time of 24 hours or less. The policy did not distinguish between examination modality or request priority. VHA requires completion of routine specialty consultations within 30 days. At the time of our review, Imaging Service staff were scheduling routine MRIs for late November 2005.

We also identified a delayed MRI that was ordered with an urgent priority. On January 10, 2005, a provider ordered an urgent MRI for a patient with sudden onset, progressive vertigo. On March 28, 2005, the provider noted that the patient was still symptomatic, yet the MRI had not been completed. On June 28, 2005 (147 days later), Imaging Service staff completed the MRI. According to the healthcare system's policy, the MRI should have been completed in 1 day. While this patient's brain scan was normal, his symptoms could have reflected a serious neurological problem requiring immediate medical attention.

To reduce its MRI backlog, Imaging Service managers are outsourcing MRIs and making arrangements to expand the MRI schedule to include evening and weekend hours.

Recommendation 4. We recommended that the VISN Director ensure the Healthcare System Director requires that (a) MRI examinations be completed timely and (b) Imaging Service's MRI policy regarding timeliness be updated.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that designated radiology staff are now dedicated exclusively to the scheduling of MRIs. Imaging service hours have also been extended and the healthcare system is exploring the use of additional contract MRI facilities. In addition, the healthcare system is revising its MRI policy to reflect VHA timeliness standards. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management – Patient Safety and Performance Improvement Activities Needed Improvement

Condition Needing Improvement. Some patient safety activities and performance improvement (PI) functions were not being completed as required in healthcare system policy. We identified one wrong-site surgery case from 2003 that should have been reviewed via the RCA process but was not. We also reviewed 22 RCAs completed in 2004 and 2005 and 3 HFMEAs completed in 2004. We determined that actions and outcome measures were not tracked to completion in 14 RCAs (64 percent) or in any of the 3 HFMEAs. In addition, 10 RCAs (45 percent) were not completed within 45 days as required. Without tracking of outcome measures, managers could not determine whether the corrective actions were effective.

Although PI data was collected, it was not consistently trended and analyzed. Healthcare system policy states that data should be displayed, compared, and evaluated using appropriate statistical analysis. Trending and analysis assists managers to identify problem areas and deficient processes and to devise appropriate corrective action plans.

Recommendation 5. We recommended that the VISN Director ensure the Healthcare System Director requires that: (a) RCAs be completed on all appropriate cases within 45 days, (b) RCA and HFMEA corrective actions be tracked to completion and outcomes be measured to determine their effectiveness, and (c) PI data be trended and analyzed.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that the RCA process has been changed to ensure that the 45-day time standard is met. Actions and outcome measures are now being tracked and the healthcare system is developing a method for trending and analyzing PI data. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Condition Needing Improvement. The healthcare system needed to strengthen controls over timekeeping for part-time physicians. All of the healthcare system's 117 part-time physicians had signed agreements describing VA's expectations and the physicians' responsibilities. In addition, we verified that all 10 of the physicians we selected for an unannounced roll call on July 18–19, 2005, were performing VA duties during scheduled core hours or had submitted appropriate leave requests. However, we identified three issues that required management attention.

Designation of Core Hours. VHA policy allows part-time physicians to work adjustable tours of duty when they have patient care, research, or educational responsibilities that make adherence to a regularly scheduled tour of duty difficult. The adjustable tours of

duty are made up of core and non-core hours. Core hours are the days and times in a biweekly pay period when part-time physicians must be present unless granted leave or excused absences. Part-time physicians who work adjustable tours of duty are required to designate at least 25 percent of their total work hours as core hours. We reviewed the tours of duty for all 117 part-time physicians and found that 2 part-time physicians had not designated at least 25 percent of their total work hours as core hours.

Preparation of Time and Attendance Records. VHA policy states that part-time physicians will record their hours of duty and leave each week on subsidiary time sheets and sign the time sheets. We reviewed the subsidiary time sheets for five physicians and found that one of the physicians was not recording the hours worked on the subsidiary time sheets.

Submission of Requests to Change Tours of Duty. The healthcare system's policy requires that a request to change a part-time physician's tour of duty be approved in writing by the physician's service chief and the Chief of Staff. After performing a technical review of the request, Human Resources personnel forward the request to the Payroll Section for processing. In February 2005, a part-time physician submitted a request for a change in tour of duty to reduce his biweekly hours from 40 to 20. The request was approved by the physician's immediate supervisor and forwarded to Human Resources. Because the service chief and the Chief of Staff did not approve the request, Human Resources and Payroll Section personnel did not complete the actions needed to adjust the physician's tour of duty. However, the part-time physician began working 20 hours per pay period. To correct the physician's pay, the part-time physician's timekeeper showed the physician was on leave without pay for portions of each pay period. Despite the compensating action taken by the timekeeper to correct the physician's pay, the physician's special pay was still based on 40 hours per pay period and the physician was not accruing the proper amount of annual leave. Based on our review, we recommended that the healthcare system take action to recover the overpayment of special pay that was made to the part-time physician. The healthcare system calculated the amount of the overpayment and issued a bill to the part-time physician to recover $7,086. In addition, the healthcare system will correct the physician's annual leave balance.

Recommendation 6. We recommended that the VISN Director ensure the Healthcare System Director requires that part-time physicians: (a) designate at least 25 percent of their total work hours as core hours, (b) record their hours worked on subsidiary time sheets, and (c) change their tours of duty only after written requests have been properly approved and processed through the Payroll Section.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that all part-time physicians have designated at least 25 percent of their total work hours as core hours. VISN 9 has established a goal of 100 percent compliance for part-time physicians recording their hours worked on

subsidiary timesheets, and the VISN will monitor compliance via a monthly audit report. In addition, the healthcare system has developed a process to ensure that physicians change their tours of duty only after the Payroll Section receives a memorandum that has been properly approved. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Condition Needing Improvement. The healthcare system needed to maintain accurate inventory records and reduce stock levels of supplies. VHA policy establishes a 30-day supply goal and requires that medical facilities use the automated Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, the healthcare system's supply inventory included 7,137 line items valued at $1,250,904.

Inaccurate Inventory Records. The healthcare system was not maintaining accurate inventory records. To assess the accuracy of GIP and PIP data, we inventoried 14 medical, 10 engineering, and 10 prosthetics line items with a combined recorded value of $50,209. The stock levels recorded in GIP and PIP were inaccurate for 12 (35 percent) of the 34 line items, with 7 shortages valued at $30,305 and 5 overages valued at $3,347. The inaccurate inventory records occurred primarily because healthcare system personnel did not promptly record receipts and distributions of supplies. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. The healthcare system needed to reduce stock levels of supplies. We compared the quantities on hand to usage data for the 34 line items that we inventoried to determine if stock levels exceeded the 30-day supply goal. Our review showed that the healthcare system needed to reduce stock levels for 5 (15 percent) of the 34 line items. The value of the excess stock was $3,131. Because GIP and PIP data was unreliable, we did not attempt to estimate the total value of the healthcare system's excess stock.

Recommendation 7. We recommended that the VISN Director ensure the Healthcare System Director requires that: (a) differences be reconciled and GIP and PIP inventory records be corrected as appropriate, (b) receipts and distributions be recorded promptly, and (c) stock levels be reduced to meet the 30-day supply goal.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that an action plan has been developed to ensure that inventory records are corrected, receipts and distributions are recorded promptly, and stock levels are reduced to meet the 30-day supply goal. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Healthcare System Memorandums – Most Policies Were Expired

Condition Needing Improvement. Thirty-nine (81 percent) of 48 policies related to patient care, QM, and medical staff were expired. Some policies expired in March 2004, more than 16 months prior to our site visit. Healthcare system policies provide clinical and clinical support staff with current guidance on areas such as standards of care, QM procedures, and professional expectations. Availability of current policies increases the likelihood that staff members will provide consistent care and services.

Recommendation 8. We recommended that the VISN Director ensure the Healthcare System Director requires that (a) all currently expired policies be updated and (b) all policies be periodically reviewed and updated prior to expiration.

The VISN and Healthcare System Directors agreed with the finding and recommendations and reported that all expired policies will be updated by December 31, 2005. In addition, the healthcare system has developed a schedule for periodically reviewing policies prior to their expiration. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 9 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 9, 2005

From: Director, Veterans Integrated Service Network 9

Subject: **VA Tennessee Valley Healthcare System**

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

1. Attached please find VA Tennessee Valley Healthcare System's response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted July 18 -22, 2005.

2. I concur with the Medical Center Director's comments and action plan.

3. Contact Ms. Donna Savoy, Staff Assistant to the Network Director if you have any questions or need additional information. She can be reached at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 3, 2005

From: Director, VA Tennessee Valley Healthcare System

Subject: **VA Tennessee Valley Healthcare System**

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

1. I would first like to extend my appreciation and that of the VA Tennessee Valley Healthcare System (TVHS) staff to the OIG CAP Team for their professional and fair approach to our review. The focus was always maintained on improvement of patient care and organizational processes.

2. I have reviewed the DRAFT Report, concur with the findings and submit to you our Action Plans for all identified Recommendations.

3. If you have any questions or require additional information, please do not hesitate to contact my office at (615) 327-5332.

(original signed by:)

David N. Pennington, FACHE

Healthcare System Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommend the VISN Director ensure the Healthcare System Director requires that preaward audits by the OIG be requested when required.

Concur, In Part **Target Completion Date:** 11/1/05

We concur with the Recommendation as stated. Acquisitions has implemented a review process by staff at least one-level above the contracting officers to assure that all contracts have the required pre-award and other legal/technical review prior to award. This process will be monitored in collaboration with VISN 9 Chief Logistics Officer and TVHS Director.

We do not concur with the identified savings amount (Monetary Benefits) as estimated by the IG attributed to pre-award audits. The Contracting Officers negotiated prices below fair market value based on available information; therefore, we do not believe Pre-Award Audits would have identified further savings.

Recommendation 2. We recommend that the VISN Director ensure the Healthcare System Director requires that: (a) Fee-Basis Unit and Social Work Service personnel promptly forward the documentation needed for billing insurance carriers to the Customer Accounts Center, (b) medical care providers adequately document resident supervision and the care provided in veterans' medical records, and (c) all billable fee-basis and VA care be identified and billed.

Concur **Target Completion Date:** 12/31/05

a) Improved Billing: New process initiated July 2005: Goal - Maximize the billing opportunities by the MidSouth Customer Accounts Center (MCAC). 1) When making a Fee Basis payment, "Fee Patient Inquiry" automatically appears on the Fee Clerk's computer screen identifying the veteran's insurance information; 2) When a veteran is identified as having insurance, the Fee Basis Clerk makes a copy of the bill that is being paid and all copies are forwarded to MCAC for billing; 3) Social Work has established the same process as stated above for the Fee Basis Unit with the Social Work clerk making the copies and forwarding to MCAC; 4) DSS has run a report (date range December 2004 - September 2005) identifying Fee Basis payments made by Social Work Service for veterans with health insurance. MCAC will identify billable episodes of care from this report and paid bills meeting that category (billable) will be pulled and copied for MCAC for billing; and, 5) DSS ran a report (date range December 2004 - June 2005) identifying Fee Basis payments made by Fee Basis for veterans who have health insurance. The identified paid bills are being pulled and copies forwarded to MCAC.

b) Resident Supervision: FY06 Performance Contracts for the Chief of Staff and Clinical Chiefs clearly define their responsibility and accountability for ensuring the documentation of resident supervision. All Clinical Chiefs have been directed to have their staff use specified templates to ensure all requirements of documentation are met. Compliance is monitored per service to the provider level with monthly reporting to the Service Chief and aggregate reports to the Compliance Committee with recommended actions being forwarded to the Chief of Staff and Director for follow-up actions required. Additional validation of compliance is provided by external reviews from EPRP and MCAC "Reasons Not Billed Report".

c) All Billable Fee Basis and VA Care Identified: DSS reports will provide an ongoing process to monitor all billing opportunities actualized by comparing Fee Basis and VA care payments made for veterans with health insurance to what MCAC actually billed.

Recommendation 3. We recommend that the VISN Director ensure the Healthcare System Director requires that the healthcare system comply with the timeliness standards established in the GI Service Agreement.

Concur **Target Completion Date:** 12/31/05

In order to comply with the Service Agreement timeliness standards, the following actions are being taken: 1) Reviewing need for physician extenders (NP/PA) to assist with triage of patients/consultations and ACA implementation; 2) Consider use of space contiguous to GI Lab (Nashville) for GI Clinic area to improve physician efficiency; 3) Requested VACO funded third (3rd) GI Fellow from ACOS/Education to provide same day consultation; and, Monitor effectiveness of actions by monthly review of GI Consults status and Performance Measure Report with reporting to the Chief, Medicine Service and Chief of Staff.

Recommendation 4. We recommend that the VISN Director ensure the Healthcare System Director requires that (a) MRI exams be completed timely and (b) Imaging Service's MRI policy regarding timeliness be updated.

Concur **Target Completion Date:** 12/31/05

a) Timeliness - 1) Radiology Service has designated staff dedicated exclusively to the scheduling of MRIs, including collaborating with clinical staff to determine level of urgency, seeking alternate locations, contacting patients to provide appointment information; 2) Screening of requests is performed on a daily basis by Radiologist to determine appropriateness of request and level of urgency, denials are directly communicated to requesting clinician with rationale for denial and recommendation(s) for alternate diagnostics, when appropriate; 3) Extending in-house hours; 4) Identifying additional contract MRI facilities and technical staff; and, 5) Effectiveness of actions (time of request to time of study) being monitored by Chief, Radiology and Chief of Staff.

b) Policy - The policy is currently being revised to reflect VHA standard for interpretation/verification of 48 hours and scheduling parameters for emergent, urgent and routine diagnostic studies. Monitoring will be incorporated as part of "a" above.

Recommendation 5. We recommend that the VISN Director ensure the Healthcare System Director requires that: (a) RCAs be completed on all appropriate cases within 45 days, (b) RCA and HFMEA corrective actions be tracked to completion and outcomes be measured to determine their effectiveness, and (c) PI data be trended and analyzed.

Concur **Target Completion Date:** 12/31/05

a) RCA Timeliness - The TVHS Patient Safety Coordinator (PSC) who has operational oversight of RCAs has decreased the timeframe assigned to the teams to ensure there is sufficient time for review prior to the Director's signature. Since July 2005, all three (3) RCAs conducted have met the 45-day timeframe. Timeliness has been added to quarterly RCA report to the PI Committee (PIC).

b) RCA/HFMEA Tracking - All 22 of the RCAs and 3 HFMEAs reviewed by the OIG Team have been reviewed for completion and evidence of measurable outcomes. Tracking and updates will be entered into SPOT database by December 31, 2005, with inclusion of any new RCA/HFMEAs. Monitoring for compliance will be part of quarterly report to PI Committee (minutes forwarded to Governing Council).

c) PI Data Tracking/Trending - 1) Under the auspices of the PI Committee (PIC), all services have been requested to provide a listing of improvement activities and monitors, including reason for monitoring activity (e.g., JCAHO/VHA requirements, etc.). Recommendations will be made as to data display, including use of statistical tools and analysis; 2) In collaboration with Education Service, staff will be provided educational opportunity to access "Applied Principles of Quality Improvement, Data Management and Measurement" course; and, 3) Reports will be reviewed to assess improvement with feedback to services.

Recommendation 6. We recommend that the VISN Director ensure the Healthcare System Director requires that part-time physicians: (a) designate at least 25 percent of their total work hours as core hours, (b) record their hours worked on subsidiary time sheets, and (c) change their tours of duty only after written requests have been properly approved and processed through the Payroll Section.

Concur **Target Completion Date:** 12/31/05

a) Core Hours - Assessment of clinical services conducted the week of 10/31/05, indicates that all part-time physicians have at least 25% designated as core hours and Service Chiefs are reviewing ongoing compliance with timekeepers and Compliance Officer.

b) Subsidiary Timecard - Assessment of clinical services indicates a goal of 100%, this is now a new part of the VISN 9 Part Time Physician & Attendance Audit Summary Report generated monthly with direct communication to Service Chiefs, Timekeepers and Chief of Staff.

c) Tour of Duty Change - The Payroll Section now notifies the timekeeper of the approved change in tour of duty upon receipt of the memorandum approved by all involved parties. For an increase or decrease in hours, a HR personnel action is required and it processed by Payroll upon request from HR. The timekeeper is also notified by Payroll when these actions are complete.

Recommendation 7. We recommend that the VISN Director ensure the Healthcare System Director requires that: (a) differences be reconciled and GIP and PIP inventory records be corrected as appropriate, (b) receipts and distributions be recorded promptly, and (c) stock levels be reduced to meet the 30-day supply goal.

Concur **Target Completion Date:** 12/31/05

Items a - c: A thorough review of all areas and processes was conducted by Logistics Manager and staff resulting in the following Action Plan: 1) Set up Operating Room Core Secondary (Nashville Campus) to eliminate the need for OR staff to enter SPD area and remove supplies except in an emergency - 12/31/05; 2) Reduce Access to SPD (Nashville Campus) from previous eight (8) door open access points - work orders entered to modify doors and eliminate direct entry - 12/1/05; 3) Inventory Management Training - ACY and Nashville Campuses - initiated 8/1/05 and ongoing will be used to ensure that staff reconcile differences in inventory records and make corrections as appropriate. The training will also emphasize that receipts and distributions will be recorded promptly; 4) Employee Re-Alignment (ACY Campus) to match skill sets with practices - completed 9/2/05; 5) Consolidated/Shared Purchases of Items shared by both campuses - initiated 9/15/05; 6) Usage Demands/Working with Using Services - collaboration between SPD and clinical services to ensure needs are met proactively - initiated 7/25/05 and ongoing; 7) 10% Inventory Counts are being conducted monthly with goal to meet VA Handbook 1761.2 inventory stock requirements of not more than 30 days (total aggregated inventory values versus individual items) - initiate 11/18/05; and, 8) Semi-Annual Inventory (Wall-to-Wall) to be conducted 1/31/06.

Recommendation 8. We recommend that the VISN Director ensure the Healthcare System Director requires that (a) all currently expired policies be updated and (b) all policies be periodically reviewed and updated prior to expiration.

Concur **Target Completion Date:** 12/31/05

a) Update Expired Policies - Phase 1: Business Office generated a spreadsheet of all TVHS policies providing capability of sorting by service, topic and/or expiration date. Phase 2: Services have been given until 11/4/05, to respond with assessment of all policies identifying number expired; validation of need (JCAHO/VHA/TVHS); and, plan for revision and/or rescission of policies. Phase 3: Senior leaders will review complete listing and service plans for concurrence. Phase 4: All expired policies identified as required will be updated and published by 12/31/05.

b) Periodic Policy Review - Business Office has developed a schedule for revisions by service by month with compliance to be monitored by both Business Office and Quality Management with reporting to the Governing Council.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Preaward audits would result in reduced contract prices.	$983,531
2	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	34,637
6	Recovering an overpayment of special pay would make funds available for other uses.	7,086
7	Reducing stock levels would make funds available for other uses.	3,131
	Total	$1,028,385

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Appendix E

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