Department of Veterans Affairs
Office of Inspector General

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

Report No. 06-00012-49 **January 5, 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 October 31 – November 4, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (the medical center), Lexington, Kentucky. 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 3 fraud and integrity awareness briefings to 123 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 9.

Results of Review

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

- Contract Award and Administration
- QM
- Radiology and Laboratory Timeliness
- Environment of Care
- Follow-up to Previous CAP Recommendations
- Controlled Substances Management
- Management of Accounts Receivable, Accounts Payable, and Accrued Services Payable

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

- Improve Peer Review Committee documentation.
- Improve controls over inventory management.
- Conduct reviews of Government purchase cards.

We reviewed the All Employee Survey results and made no recommendations.

This report was prepared under the direction of Ms. Victoria Coates, Director, Atlanta Regional Office of Healthcare Inspections, and Ms. Bertie Clarke, CAP Team Leader, Atlanta Regional Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN and Medical Center Directors concurred with the CAP review findings and provided acceptable improvement plans. (See pages 8-12 for the full text of the Directors' comments.) We will follow up on planned improvement actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The VA Medical Center Lexington, Kentucky, is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at one community-based outpatient clinic located in Somerset, Kentucky. The medical center is part of VISN 9 and serves a veteran population of about 89,000 in a primary service area that includes 37 counties in central Kentucky.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 99 hospital beds and 61 nursing home care unit (NHCU) beds and operates several regional referral and treatment programs, including a 20-bed inpatient post-traumatic stress disorder residential treatment program. The medical center also has sharing agreements with the Federal Bureau of Prisons, Bluegrass Army Depot, and the Kentucky Department of Veterans Affairs.

Affiliations and Research. The medical center is affiliated with the University of Kentucky and supports 86 medical resident positions in 26 training programs. The medical center also holds affiliations with 19 additional colleges and universities.

In Fiscal Year (FY) 2005, the medical center research program had 69 projects and a budget of $3.8 million. Important areas of research include thyroid cancer treatment, prostate cancer treatment, and gylcemic control in the treatment of Type II Diabetes.

Resources. In FY 2005, medical care expenditures totaled $160,232,850. The FY 2006 medical care budget is $167,673,467. FY 2005 staffing totaled 1,294 full-time equivalent (FTE) employees, including 75 physician and 234 nursing FTE.

Workload. In FY 2005, the medical center treated 5,685 unique patients. The medical center provided 26,277 inpatient days of care in the hospital and 20,715 inpatient days of care in the NHCU. The inpatient care workload totaled 5,717 including NHCU discharges, and the average daily census was 128.7. The outpatient workload was 293,981 visits.

Objectives and Scope of the CAP Review

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

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of 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 the recommendations of our previous CAP review of the medical center (Combined Assessment Program Review of VA Medical Center Lexington, Kentucky, Report No. 02-01933-3, October 16, 2002).

The review covered facility operations for FY 2004 and FY 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:

All Employee Survey	Management of Accounts Receivable, Accounts Payable, and Accrued Services Payable
Contract Award and Administration	Peer Review
Controlled Substances Management	Quality Management
Environment of Care	Radiology and Laboratory Timeliness
Follow up to Previous CAP Findings	Supply Inventory Management
Government Purchase Card Program	

As part of the review, we used questionnaires and interviews to survey patient satisfaction with the timeliness of services and quality of care. The survey results were provided to medical center management.

During this review, we also presented 3 fraud and integrity awareness briefings to 123 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. Areas needing improvement are discussed in the Opportunities for Improvement section (pages 4-6). Findings from the All Employee Survey review are discussed in the Other Area Reviewed section (page 6).

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 other areas not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Opportunities for Improvement

Peer Review – Committee Documentation Needed Improvement

Condition Needing Improvement. Peer Review Committee meeting minutes did not adequately document committee members' case discussions. Peer reviews evaluate the care provided by individual medical practitioners for the purpose of improving quality of care or resource utilization. The Peer Review Committee reconsiders all peer reviews that are initially determined to be Level II or III, meaning that most experienced, competent practitioners might have, or would have, handled the case differently.

VHA Directive 2004-054, dated September 29, 2004, requires that formal discussions occurring during Peer Review Committee meetings are recorded in formal meeting minutes. In the 3rd and 4th quarters of FY 2005, five of seven peer reviews initially categorized as Level II or III were changed to lower levels of severity by the Peer Review Committee, yet committee minutes contained minimal evidence of the rationale for these changes. Without proper documentation, managers could not be assured that peer review severity levels were being changed for justifiable reasons.

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director requires that Peer Review Committee discussions about changes to severity levels are recorded in formal committee meeting minutes.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Medical center management developed a template to assure documentation of Peer Review Committee deliberations. We will follow up on the planned action until it is implemented.

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 for inventory control points (ICPs). GIP inventory records did not accurately reflect inventory balances for the five ICPs we tested.

The medical center's 13 ICPs had 3,128 inventory line items valued at about $852,700, as of August 31, 2005. We reviewed a judgment sample of 60 stock items valued at about $130,984 from the 5 ICPs (Supply Processing and Distribution (SPD), Cardiac Catherization Laboratory (Cath Lab), Radiology Service, Laboratory Service, and Endoscopy) with the highest inventory values and found that inventory records were not

accurate for 34 items (57 percent). Balances for 21 items were overstated by about $25,000 (less stock on hand than recorded in GIP) and balances for 13 items were understated by about $61,000 (more stock on hand than recorded in GIP), a net difference of about $36,000. The results of the counts were as follows:

ICP	Items Counted	Number of Incorrect Balances	Accuracy Rate	GIP Inventory Value	Adjusted Value	Variance
SPD	20	8	60%	$ 41,955	$ 39,556	$(2,399)
Cath Lab	10	3	70%	45,281	45,525	244
Radiology	10	9	10%	27,032	18,310	(8,722)
Laboratory	10	10	0%	11,540	56,669	45,129
Endoscopy	10	4	60%	5,176	6,520	1,344
Total	60	34	43%	$130,984	$166,580	$35,596

VA's minimum inventory accuracy rate of 90 percent was not met by any of the ICPs reviewed. This occurred because the staff did not post receipts and disbursements timely, some bar coding labels were missing, and some item nomenclature and units of issue needed updating in GIP.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) GIP records contain accurate inventory balances, (b) ICP stock usage is entered into GIP timely, (c) missing bar code labels are replaced, and (d) GIP records contain accurate nomenclature and units of issue information.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the facility will combine stand-alone primary inventory accounts with the main SPD primary inventory, and those accounts will become secondary inventory, thus allowing using Services to pull stock without affecting primary inventory stock balances. This action will improve timeliness of stock usage entry. In addition, actions were taken to replace missing bar code labels, and staff have received in-service training on inventory account management. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Transactions Needed Proper Reconciliation

Condition Needing Improvement. The medical center did not ensure that cardholders reconcile purchase card transactions properly. During the period October 1, 2004, through September 26, 2005, cardholders processed 26,458 transactions totaling about $16 million. While cardholders generally met Veterans Health Administration (VHA)

requirements for reconciling completed transactions, some transactions were not reconciled properly, which resulted in the transactions not being approved within 14 days, as required by VHA policy. Our review found 34 transactions totaling about $173,000 that cardholders had not properly processed. As a result, the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system had not alerted approving officials that these transactions needed approval.

At our request, the Purchase Card Coordinator initiated a review and identified 13 additional transactions totaling about $24,000 from FYs 2003 and 2004 that also had not been approved.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires medical center staff to: (a) develop processes and procedures for systematically monitoring unapproved transactions and follow up with cardholders and approving officials to ensure that unapproved transactions are for official purposes, and (b) provide training to cardholders on the proper method of reconciling transactions.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. To address a glitch in the Purchase Card program, a template has been developed for use in all VISN 9 facilities that identifies unapproved transactions in the system that require action. Also, Purchase Card holders and approving officials will receive annual training. We will follow up on the planned actions until they are implemented.

Other Area Reviewed

All Employee Survey – Data Utilized to Improve Employee Satisfaction

The medical center utilized All Employee Survey (AES) data to improve employee satisfaction. VHA administers an AES every 3 years to assess employee and organizational satisfaction. An Executive Career Field performance plan measure required VISN directors to analyze the employee survey results and develop an action plan to address areas in need of improvement by September 30, 2004.

Results of the 2004 AES revealed low levels of employee satisfaction. Medical center employee responses were below[1] VISN means in two parameters and below national means in 18 of 34 parameters. Medical center managers communicated results of the AES by inviting employees to attend one of 12 focus groups. The focus groups afforded the employees the opportunity to provide further feedback. Medical center managers developed an action plan to address three areas identified as needing improvement. Action plan items targeted communication, supervisor training, and rewards and recognition.

[1] Statistically significant difference.

The new Medical Center Director told us improving employee morale and satisfaction is one of her top three priorities. She has implemented several initiatives to this end, including strategic retreats, regular senior management team rounds in all service areas, and quarterly rewards and recognition programs. Because management was taking actions, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2005

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

Subject: **Combined Assessment Program Review of the VA Medical Center, Lexington, Kentucky, Project Number 2006-00012-HI-0001**

To: Assistant Inspector General for Healthcare Inspections thru: Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of the OIG CAP Survey Team relative to the Lexington VA Medical Center and am pleased to forward the attached action plan. The team was professional and diligent in its review of the areas encompassed in the report. VISN 9 welcomes the partnership with OIG in ensuring excellent and efficient services to the veterans we serve.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Donna Savoy, Staff Assistant to the Network Director at 615-695-2205 or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 1, 2005

From: Medical Center Director (596/00)

Subject: **Combined Assessment Program Review of the VA Medical Center, Lexington, Kentucky, Project Number 2006-00012-HI-0001**

To: Assistant Inspector General for Healthcare Inspections thru: Director, Management Review Service (10B5)

1. On behalf of the Lexington VA Medical Center, I would like to express our appreciation for the professional and constructive approach of the OIG CAP team in conducting its on site review in November 2005.

2. Attached you will find our concurrence with all recommendations made as well as an outline of improvement actions and timelines. We believe these changes will enhance operational efficiences and resource accountability at our facility.

(original signed by:)

Sandy J. Nielsen

Medical Center Director

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 Report:

OIG Recommendation(s)

Recommendation 1. We recommend the VISN Director ensure the Medical Center Director requires that Peer Review Committee discussions about changes to severity levels are recorded in formal committee meeting minutes.

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

A revised template for capturing more substantive information about peer review decisions and concurrences was developed and shared with the OIG CAP team members while on site. They concurred that the new template would provide appropriate documentation of peer review deliberations. Peer Review Committee minutes will be documented based on this template effective December 2005.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) GIP records contain accurate inventory balances, (b) ICP stock usage is entered into GIP timely, (c) missing bar code labels are replaced, and (d) GIP records contain accurate nomenclature and units of issue information.

Concur **Target Completion Date:** 03/31/06

(a) Inservices and reminders are given to staff at regular intervals regarding posting of stock removed from the primary. Employees not recording called-for items, pickup items, and the use of stand-alone Primary accounts, make up most of the mistakes that were found in the primaries. The main reasons for inaccurate inventory counts in Stand Alone Primaries is because Using Service staff are pulling stock at the point of use, so it is impossible for the count to be exact at any point in time. Consequently, we are combining our stand-alone primaries with our main SPD primary, and those inventory points will now be secondaries so that the using services can pull their stock, as required, without interfering with the Primary stock balances.

(b) The timeliness issues will be resolved with the conversion of stand-alone primary inventory accounts to secondary accounts, as described in paragraph (a).

(c) Disciplinary actions were taken for the Item Manager assigned to the Laboratory Service inventory account, as the labels had been removed and corrective action was not taken following the Network staff's audit. The assigned Item Manager has been given a completion date of 12/12/05 to correct the inventory account. Disciplinary action was taken, and inservice training was given to assigned staff in Radiology during the OIG visit.

(d) This is the same issue in Laboratory Service as described in paragraph (c) and will be resolved by the date stated above.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director requires medical center staff to: (a) develop processes and procedures for systematically monitoring unapproved transactions and follow up with cardholders and approving officials to ensure that unapproved transactions are for official purposes, and (b) provide training to cardholders on the proper method of reconciling transactions.

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

(a) There is a glitch in the Purchase Card program that fails to notify the approving official when an amendment is reconciled, and the Purchase Card Coordinator had no way to determine that there were pending unreconciled transactions. A template has been developed and will be used in all VISN 9 facilities that identifies unapproved transactions in the system, which will then be followed up by the Purchase Card Coordinator with the appropriate Approving Officials for approval.

(b) Training will be conducted annually for all Purchase Card Holders and Approving Officials regarding the proper method for reconciling Purchase Card transactions. This is ongoing.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Floyd C. Dembo, CGFM, Audit Manager Bertie Clarke, Healthcare Inspections Team Leader Leon Roberts, Audit Team Leader Mike Keen, Investigations Team Leader Ann Batson Brian Celatka Harvey Hittner George Patton Christa Sisterhen Alvin Wiggins Susan Zarter

Appendix D

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