



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Review of the Veterans Health Administration Activities at the Robert J. Dole VA Medical Center Wichita, Kansas**

## **Office of Inspector General**

### **Combined Assessment Program Reviews**

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

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

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

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# Executive Summary

## Introduction

During the week of December 5–9, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Robert J. Dole VA Medical Center (the medical center), Wichita, Kansas. 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 fraud and integrity awareness training to 112 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

## Results of Review

The CAP review covered 10 operational activities. The medical center complied with selected standards in the following three activities:

- All Employee Survey
- Environment of Care
- Information Technology Security

We made recommendations in 7 of the 10 activities reviewed. For these activities, the medical center needed to:

- Enhance Medical Care Collections Fund (MCCF) program results by billing all fee-basis care and improving medical record documentation.
- Reduce supply inventories to meet the 30-day goal and update Generic Inventory Package (GIP) records to match the actual quantities on hand.
- Cancel unneeded obligations and services payable.
- Improve controls over purchase cards by reducing monthly credit and single purchase limits, securing cards from inappropriate access, and separating duties.
- Strengthen controls over prescription drugs by segregating duties and randomly scheduling unannounced inspections.
- Improve QM analysis, documentation, implementation, and reporting processes.
- Strengthen the process of reporting suspicious or abnormal mammograms to providers.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

## **VISN 15 and Medical Center Director Comments**

The VISN 15 and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 14-20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

## Introduction

### Facility Profile

**Organization.** Based in Wichita, KS, the medical center provides inpatient and outpatient health care services. Outpatient care is also provided at community-based clinics located in Parsons, Salina, Hays, Fort Dodge, and Liberal, KS. The medical center is part of VISN 15 and serves a veteran population of about 100,400 in a primary service area that includes 51 counties in KS.

**Programs.** The medical center provides medical, surgical, neurological, geriatric, hospice, and rehabilitation services. The medical center has 41 hospital beds and 40 nursing home care unit (NHCU) beds.

**Affiliations and Research.** The medical center is affiliated with the University of Kansas School of Medicine–Wichita and supports 21 medical residents in 5 training programs. There are nursing student affiliations with Wichita State University and Butler County Community College. There are 18 other affiliations involving social work, optometry, audiology, speech pathology, and physician assistants training programs. The Kansas City VAMC provides research oversight.

**Resources.** In FY 2005, the medical center's expenditures totaled \$92.4 million. The FY 2005 budget was \$93.9 million, a 17 percent increase over the FY 2004 budget. FY 2005 staffing was 605 full-time equivalent employees (FTE), including 36 physician and 205 nursing FTE.

**Workload.** In FY 2005, the medical center treated 27,713 unique patients, a 1 percent increase from FY 2004. The inpatient care workload, including NHCU, totaled 2,560 discharges and the average daily census was 68. The outpatient workload was 247,107 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 management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 10 activities:

All Employee Survey	Information Technology Security
Breast Cancer Management	Medical Care Collections Fund
Controls Over Prescription Drugs	Quality Management
Environment of Care	Supply Inventories Management
Government Purchase Card Program	Unliquidated Obligations

The review covered medical center operations for FY 2005 through November 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of Veterans Health Administration Activities at the Robert J. Dole VA Medical and Regional Office Center*, Report No. 03-02735-103, March 16, 2004).

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

During this review, we also presented fraud and integrity awareness briefings for 112 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, 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. Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-12). For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

## Results of Review

### Opportunities for Improvement

#### Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries

**Condition Needing Improvement.** Medical center managers could increase MCCF program results by billing all fee-basis care and training providers to improve medical record documentation. The medical center collected \$5.65 million in FY 2004, exceeding its collection goal of \$4.35 million. During FY 2005, MCCF managers precertified medical care with veterans' insurance providers to increase collections. Their FY 2005 collections of \$4.29 million were short of the goal of \$6.02 million because of additional time and documentation requirements for Medicare remittance.<sup>1</sup> We found additional collection opportunities and estimated that increased annual collections of \$44,792 could have been achieved, as discussed below.

Fee-Basis Care. For the 3-month period ending June 30, 2005, the medical center paid 266 fee-basis claims totaling \$143,070 to non-VA providers who furnished medical care to veterans with health insurance. Payments included claims for care provided to inpatients and outpatients. We reviewed a sample of 20 claims to determine if the medical center billed the fee-basis care to veterans' insurance carriers. MCCF staff billed for one of these claims. Seventeen of the remaining 19 claims were not billable because the fee-basis care was for service-connected (SC) conditions, the services provided were not covered by the veterans' insurance policies, or the veteran did not have insurance at the time of his fee care. The other two claims were billable, and MCCF staff initiated bills for \$3,053 during our review. Beginning in July 2005, MCCF staff implemented new procedures and software to identify all billable fee-basis care.

Medical Record Documentation. MCCF staff can improve collections by training providers to fully document medical care promptly and to select SC or Agent Orange indicator boxes only when the veterans received care for conditions that were SC or related to Agent Orange exposure.

The "Reasons Not Billable Report" for the 3-month period ending June 30, 2005, listed 124 cases totaling \$22,630, that were unbilled for 1 of 3 reasons—insufficient documentation, no documentation, or care provided by a nonbillable provider (resident). We reviewed 30 cases and found 6 cases were not billable because the services provided were not covered by the veterans' insurance. The remaining 24 cases, totaling \$21,630,

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<sup>1</sup> VAMC Wichita's FY 2005 collections declined from FY 2004 collections because it was a test site for the Medical Remittance Advice (MRA) project. The MRA software allows sites to receive an Explanation of Benefits (EOB) from Medicare. MRA information is used to create a secondary bill to those carriers who require an EOB from Medicare prior to making payment.



were billable, but providers had not sufficiently documented the episode of care in the medical records at the time MCCF staff coded the care for billing. We found sufficient documentation in the medical record to bill 8 of the 24 cases, and partial documentation for the remaining 16 cases. MCCF staff initiated bills, totaling \$17,242, for the 8 cases during our review. They are following up with clinical staff for documentation needed to bill the other 16 cases.

The “Reasons Not Billable Report” for the 3-month period ending June 30, 2005, listed 1,557 cases totaling \$455,225 that were unbilled because providers marked boxes that indicated the veterans’ medical care was for SC conditions. We reviewed 58 cases, totaling \$252,488, and found that the medical care provided was not for SC conditions in 12 cases. Providers incorrectly selected the SC indicator boxes for these cases. MCCF staff agreed and initiated bills, totaling \$14,087, for these 12 cases during our review.

The “Reasons Not Billable Report” for the 3-month period ending June 30, 2005, listed 32 cases totaling \$10,088 that were unbilled because providers marked boxes that indicated the veterans’ medical care was for Agent Orange exposure. At our request, MCCF staff reviewed these cases and agreed that the Agent Orange indicators were incorrectly selected for all 32 cases. They found that there were four providers responsible for the incorrect selections, including one who accounted for 27 of the 32 cases. The Compliance Officer and MCCF staff provided educational training concerning correct selections of the Agent Orange box to these four providers during our review. MCCF staff identified 15 of the 32 cases as billable and issued bills totaling \$2,705 for these cases. The remaining 17 cases were not billable because the veterans’ medical care was for SC conditions.

Estimated Collections. MCCF staff can enhance revenue collections by billing insurance carriers for all fee-basis care and providing training to providers to adequately and promptly document medical care and to accurately select the proper indicators for SC and Agent Orange care. Based on the medical center’s historical collection rate of 27 percent, MCCF staff could have increased collections by \$11,198 (27 percent x (\$3,053+\$21,630+\$14,087+\$2,705)). Annually, MCCF can enhance revenues by \$44,792 (\$11,198 x 4 quarters).

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) identify and bill all billable episodes of fee-basis care and (b) train medical care providers regarding proper and timely medical record documentation, including selection of the indicator boxes for SC and Agent Orange care.

The VISN and Medical Center Directors agreed with the finding and recommendations. A process is in place to capture all billable episodes of care, and the medical center will continue to monitor to ensure compliance. A nurse is validating the Agent Orange designation before billing occurs and medical center management has planned education for medical care providers regarding proper and timely medical record documentation.

The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

## **Supply Inventories Management – Inventories Should Be Reduced and Controls Strengthened**

**Condition Needing Improvement.** Logistics staff needed to reduce excess supply inventories to meet the 30-day supply goal and improve the accuracy of inventory records. Veterans Health Administration (VHA) policy establishes a 30-day supply goal and mandates that facilities use GIP to manage inventories. Inventory managers used the GIP automated inventory control system to monitor inventory levels, analyze usage patterns, and order supply quantities necessary to meet current demand.

Logistics staff established five primary inventory supply points—total supply support, office, Environment Management Service, engineering, and prosthetics. At the time of our review, the medical center reported an inventory of 1,182 items valued at \$112,513 for these five supply points. To test the accuracy of the five inventory balances and the reasonableness of inventory levels, we reviewed a sample of 30 items valued at \$17,744. For 21 of the 30 items, the supply on hand exceeded 30 days, with inventory levels ranging from 45 to 3,630 days of supply. For these 21 items, the value of stock exceeding 30 days was \$6,834, or 39 percent of the total value of the 30 sampled items. Applying the 39 percent sample result to the combined value of the five inventories, we estimated that the value of all excess stock was \$43,880.

GIP inventory balances also did not agree with our physical counts for 7 of the 30 sampled items. Three of the items were over reported (less stock on hand than reported in GIP) by \$884, while the other four were under reported (more stock on hand than reported in GIP) by \$464. These inaccuracies occurred because unauthorized personnel could access office supplies storage areas, and prosthetics staff did not update inventory records when they issued prosthetic supplies due to multiple small prosthetics storage locations distributed all over the medical center.

**Recommendation 2.** We recommended that the VISN Director ensure that VISN Logistics staff and the Medical Center Director take steps to: (a) reduce supply inventory levels to meet the 30-day supply goal, (b) update GIP inventory records to match the actual quantities on hand, (c) secure office supplies storage, and (d) secure storage areas and update inventory records timely for prosthetic supplies.

The VISN and Medical Center Directors agreed with the findings and recommendations. Supply inventory levels have been reviewed and adjusted, inaccuracies were corrected, and the Logistics staff will monitor for compliance. A wall will be constructed to separate and secure office supplies. Prosthetics will secure storage areas and ensure timely recording of stock issued. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

## **Unliquidated Obligations – Undelivered Orders and Accrued Services Payable Should Be Canceled**

**Condition Needing Improvement.** VHA policy requires that Fiscal Service staff analyze undelivered orders and accrued services payable monthly to determine whether they should be canceled and the funds reprogrammed. We identified \$18,945 in unliquidated obligations that were no longer necessary. Fiscal Service employees reviewed obligations monthly as required by VA policy and used e-mail messages to follow up with medical center staff on whether the obligations were still needed. However, Fiscal Service did not follow up if there were no responses to the e-mails.

Undelivered Orders. Undelivered orders are obligations established to pay for supplies and certain types of services that have been ordered but not yet delivered. As of November 2005, the medical center had 36 undelivered orders totaling \$122,630 that exceeded 90 days. We reviewed a sample of 10 orders and identified 8 orders (valued at \$16,650) that should have been canceled. Fiscal Service managers agreed and canceled these orders.

Accrued Services Payable. Accrued services payable are obligations established to pay the estimated costs of services contracted for but not yet received. As of November 2005, the medical center had 36 accrued services payable totaling \$567,762 that exceeded 90 days. We reviewed a sample of 10 payables and identified 1 payable (valued at \$2,295) that should have been canceled. Fiscal Service managers agreed and canceled this payable.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director emphasizes the need to (a) thoroughly review and follow up on outstanding obligations and (b) cancel those obligations that are no longer needed.

The VISN and Medical Center Directors agreed with the findings and recommendations. They established a process to review and follow up on outstanding obligations and assigned dedicated staff the responsibility to clear obligations or make final payment. The improvement action is acceptable, and we will follow up on the planned actions until they are completed.

## **Purchase Card Program – Internal Controls Needed Strengthening**

**Condition Needing Improvement.** The Purchase Card Program Coordinator and Fiscal Officer needed to improve internal controls by:

- Auditing cardholders' accounts quarterly.
- Reducing monthly credit and single purchase limits.
- Ensuring that cardholders secure purchase cards from inappropriate access.

- Separating cardholders' and approving officials' duties.

We reviewed purchase card activity for 21 cardholders with 16,233 transactions totaling \$6,596,050 for the 12-month period ending September 30, 2005.

Audit Cardholders' Accounts. VA policy requires that the Program Coordinator and Fiscal Officer conduct monthly audits of samples of purchase card transactions provided by the Financial Service Center (FSC) in Austin, TX, and quarterly audits of those cardholders' accounts not covered by the monthly audits. Medical center staff had done the monthly audits on the FSC's samples as required, but they had not done the quarterly audits since March 2005. The Purchase Card Coordinator said that this occurred due to lack of staff time.

Reduce Purchase Card Credit Limits. VA policy requires that the Program Coordinator annually assess the monthly credit and single purchase limits for government purchase card issued. These limits should be based on the expected monthly purchase of the cardholders.

We found that 95 purchase cards were set at the maximum monthly credit limit of \$999,000. However, monthly purchases for these 95 cards ranged from \$20 to \$114,822, with an average of \$5,301. The Program Coordinator should reduce the monthly credit limits of these 95 purchase cards to levels corresponding to station procurement needs.

Seven of the 21 cardholders in our sample held warrants that increased their single purchase limits to either \$50,000 or \$25,000. We found that these cardholders had been issued 77 purchase cards with single purchase limits of \$50,000 and 14 cards with single purchase limits of \$25,000. Only 7 of the 77 cards set at \$50,000 had a history of purchases that justified the single purchase limit. For the remaining 70 cards, the largest single purchase was \$19,868. The largest single purchase for the 14 cards set at \$25,000 was \$8,664. The Program Coordinator should reduce the single purchase limits on these 84 purchase cards.

Secure Purchase Cards from Inappropriate Access. VA policy states that cardholders should secure cards on their person or in a locked location that no one else can access. We interviewed five cardholders from our sample to determine how they secured their cards. Two cardholders in Pharmacy Service had three cards each. Their cards were kept in unlocked desk drawers that anyone in the pharmacy area could access. The cardholders did not secure the cards on their person because they had almost used the government cards accidentally for personal purchases. The Program Coordinator should ensure that cardholders secure purchase cards to prevent unauthorized access.

Separate Duties Between Approving Officials and Cardholders. VA policy states that there must be a clear separation of duties for making purchases, reconciling transactions with billing statements, and certifying purchase card transactions. One person cannot perform more than one of these duties for the same transaction. During FY 2005, three approving officials acted as surrogates for cardholders under their control when the cardholders were on extended leave. As a result, these approving officials both

reconciled and certified 487 purchase card transactions in order to meet timeliness requirements. Although we did not identify any inappropriate transactions, these approving officials had the ability to abuse government purchase cards without detection. The Program Coordinator should assign another approving official to certify transactions when an approving official acts as a surrogate for a cardholder under their control.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires that the Program Coordinator and Fiscal Officer: (a) audit cardholders' accounts quarterly as required, (b) reduce purchase card monthly credit and single purchase limits to match actual procurement needs, (c) ensure that cardholders adequately secure government purchase cards, and (d) separate duties so that approving officials do not both reconcile and certify the same transactions.

The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center staff are completing the backlog of audits and will then complete quarterly. The Program Coordinator will appropriately adjust monthly credit and single purchase limits during the annual audit process. Medical center management has installed locks to secure purchase cards, and approving officials' duties have been separated. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

## **Controls Over Prescription Drugs – Segregating Duties and Scheduling Unannounced Inspections Needed Improvement**

**Condition Needing Improvement.** VHA policy requires that Pharmacy Service staff have effective controls to safeguard and account for prescription drugs and maintain accountability over all pharmaceuticals. Our review identified two concerns.

Segregation of Duties. One Pharmacy Service employee could both order and receive noncontrolled pharmaceuticals from the prime vendor. As a result, the employee had the ability to divert pharmaceuticals without detection. Proper segregation of duties for the ordering and receiving of all pharmaceuticals should be implemented when practical. When duties are not segregated, random monitoring should be in place to minimize the opportunity for diversion.

Monthly Unannounced Inspections. VHA policy requires that Controlled Substance Inspection Program inspectors conduct monthly, unannounced inspections of controlled substances throughout the medical center. Inspections should be randomly scheduled during the month to ensure the element of surprise. During the 6-month period ending September 30, 2005, inspectors conducted all of the monthly, unannounced inspections during the last 2 weeks of the month because they thought inspections had to be separated by at least 2 weeks. The Controlled Substance Inspection Coordinator agreed to have inspectors conduct their inspections more randomly.

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director requires (a) proper segregation of the duties for ordering and receiving pharmaceuticals when practical, or a process for monitoring of ordering/receiving be in place and (b) random scheduling of monthly, unannounced inspections of controlled substances.

The VISN and Medical Center Directors agreed with the findings and recommendations. Pharmacy Service has increased random spot checks to maintain the ordering and receiving process, and controlled substance inspectors are conducting more random inspections. The improvement actions taken are acceptable.

## **Quality Management – Data Collection and Analysis Needed Improvement**

**Condition Needing Improvement.** Program managers needed to collect and analyze pertinent data in all areas required by VHA policy and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO requires hospitals to analyze data for trends and make recommendations to improve care. The QM program generally provided appropriate oversight of clinical care; however, five program areas needed improvement. We interviewed employees and reviewed policies, plans, committee minutes, and reports for FY 2005.

Patient Safety Aggregate Reviews. Program managers did not conduct aggregate root cause analyses (RCAs) for falls, adverse drug events, parasuicidal behaviors, and missing patients for FY 2005. The VA National Center for Patient Safety requires that medical centers complete these aggregate reviews every quarter. A review from the VISN safety officer in 2003, the 2004 CAP report, and a review from a VA national safety officer in 2005 made recommendations to improve the RCAs. The medical center had not implemented those recommendations. The Patient Safety Coordinator had not completed the reviews because employees were not capturing all reportable events and completing incident reports. As a result, data for the RCAs was inaccurate. Without appropriate aggregate reviews, medical center managers could not identify system issues or implement appropriate actions to improve patient safety.

Peer Review. Clinicians had not completed peer reviews within the VHA required timeframe and did not track results by number of reviews and level of outcomes. The VHA peer review directive requires that medical centers develop a peer review policy by March 4, 2005, and that the committee meet quarterly. The medical center did not complete the policy until June 2005, and as a result, the committee met once in 2005.

Patient Complaint Analysis. Patient complaint reports were limited to broad topic areas, such as complaints involving providers and involving appointments. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The patient advocates

needed to expand data analyses in the patient complaint program to identify meaningful trends and opportunities for improvement. The QM Coordinator agreed and had expanded the program and provided training to the advocates in October 2005.

Morbidity and Mortality Review. Although patient deaths had been reviewed on an individual basis, program managers had not consistently trended or analyzed the data. The QM Coordinator realized the deficiency and completed a retrospective trend analysis immediately prior to the CAP review.

Resuscitation Review. The medical center collected data to measure performance in responding to resuscitation events but had not trended the events by area, shift, day of the week, and outcome.

The QM Coordinator had been in the position since December 2004. She had identified opportunities to improve the program and was continuing to implement new processes.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the Patient Safety Coordinator complete the required RCAs, (b) responsible clinicians complete incident reports, (c) clinicians complete peer reviews in a timely manner, trend results, and meet quarterly as required, (d) the patient advocates perform more detailed patient complaint analyses, (e) the QM Coordinator trend and analyze morbidity and mortality data quarterly, and (f) responsible clinicians trend resuscitation events as required.

The VISN and Medical Center Directors agreed with the findings and recommendations. The QM department has developed a tracking system for RCA completions and initiated reviews. Clinical staff have been educated regarding the importance of completing incident reports and the number of reports has increased. The committee responsible for peer review has met at least quarterly and is tracking results as required. The Patient Advocate Manager is analyzing results and reporting details to the Quality and Performance Council. The QM Coordinator is providing trended analysis of morbidity and mortality reviews to designated committees. The medical center has developed a tool for trending resuscitation events and will report results to the Critical Care Committee and Clinical Practice Council. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

## **Breast Cancer Management – Communication of Suspicious or Abnormal Mammogram Results Needed Strengthening**

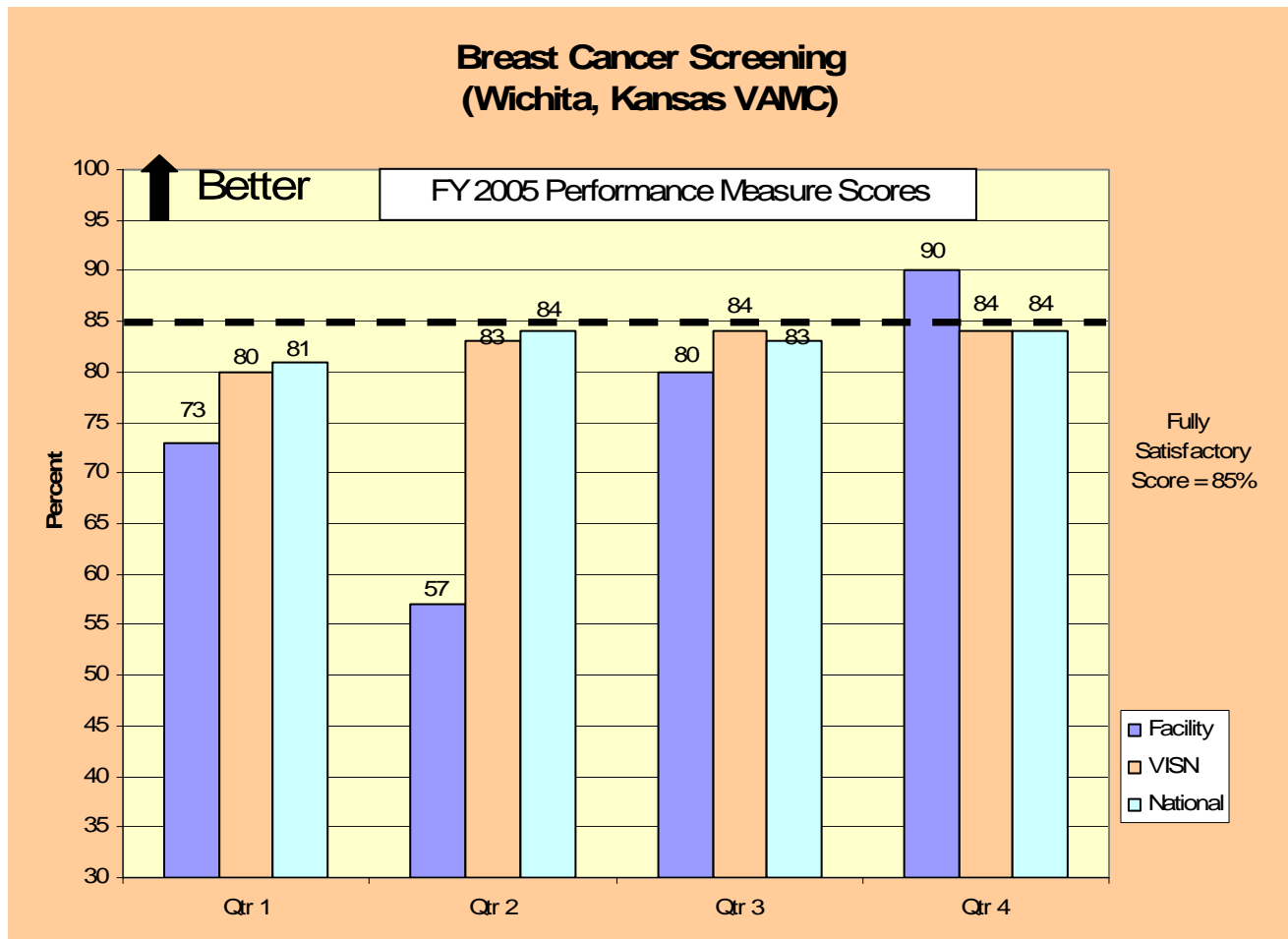
**Condition Needing Improvement.** Fee-basis facilities needed to report suspicious or abnormal mammography results to medical center providers who ordered the procedures within the required timeframe. The medical center refers all patients to community facilities for mammography procedures. There was documentation that facilities sent written reports of all procedures, including recommendations for follow-up, to patients



and the medical center within the required 30-day timeframe. However, they did not communicate suspicious or abnormal results to the ordering providers within 3 working days after the procedures, as required.

**Criteria.** The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Suspicious or abnormal results must be communicated to the ordering provider within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider. If this is the method adopted, the communication must be documented in the patient's medical record. Timely results need to be available and accessible to guide patient care and treatment. We assessed these items in a review of 10 patients who were diagnosed with breast cancer or had an abnormal mammography during FY 2005.

### Findings.





<b>Patients appropriately screened</b>	<b>Mammography results reported to patient within 30 days</b>	<b>Patients appropriately notified of their diagnoses</b>	<b>Patients received timely consultations</b>	<b>Patients received timely biopsy procedure</b>
<b>10/10</b>	<b>10/10</b>	<b>10/10</b>	<b>10/10</b>	<b>7/10</b>

Although the medical center did not meet the VHA performance measure for breast cancer screening in three of four quarters for FY 2005, 100 percent of the cases we reviewed were appropriately screened. A performance improvement team had implemented changes in the screening process that resulted in an increase in the percent of patients screened, and the medical center surpassed the fully satisfactory score for the fourth quarter. Three cases when patients did not receive timely biopsy procedures were due to circumstances outside of the control of the medical center. Clinicians had developed coordinated interdisciplinary treatment plans and provided timely Surgery and Hematology/Oncology consultative and treatment services.

In all 10 cases, there was no documentation that facilities were reporting suspicious or abnormal findings within 3 working days. The average time from the mammography until the abnormal report was available in the medical record was 8 days. Although timeliness of biopsies was not impacted, medical center managers agreed there was a lack of communication and no process for reporting these results.

**Cause.** The fee-basis referrals for mammography included the telephone number of the coordinating radiology technician but did not include contact information for the ordering provider. For this reason, the fee-basis facilities were unable to communicate abnormal results to the ordering providers within the required timeframe. Until FY 2005, the medical center was coordinating all mammography. The community-based outpatient clinics are now responsible for coordinating fee-basis mammography within their communities, and reporting processes were not consistent.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 working days and (b) document the communication in the medical record.

The VISN and Medical Center Directors agreed with the findings and recommendations. The vendor was notifying the medical center of suspicious results, but the providers were not documenting the notification. The providers are now documenting in the medical record and arranging appropriate follow-up. The improvement actions are acceptable.

## **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 average levels of employee satisfaction. There were no statistical differences between medical center employee responses and VISN 15 and national responses. VISN 15 has established a workforce development council and requires each medical center in the VISN to submit an improvement action plan. The medical center action plan identified rewards and recognition, conflict resolution, promotion opportunities, employee development, and job control as areas needing improvement. Employee education coordinators had designed training initiatives for these areas.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 15, 2006

**From:** Director, Veterans Integrated Service Network 15  
(10N15)

**Subject:** **Combined Assessment Program Review of the  
Robert J. Dole VA Medical Center, Wichita, Kansas**

**To:** Director, Kansas City Regional Office of Healthcare  
Inspections (54KC)

Attached is Wichita's response to the draft report on their  
CAP review.

I concur with their response.

*(original signed by:)*

Peter L. Almenoff, M.D., FCCP

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 14, 2006

**From:** Medical Center Director (589A7/00)

**Subject:** **Combined Assessment Program Review of the  
Robert J. Dole VA Medical Center, Wichita, Kansas**

**To:** Director, Veterans Integrated Service Network 15  
(10N15)

Attached is Wichita's response to the draft report on the  
CAP review.

*(original signed by:)*

THOMAS J. SANDERS, CHE

## **Director's Comments to Office of Inspector General's Report**

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

### **OIG Recommendation(s)**

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) identify and bill all billable episodes of fee-basis care and (b) train medical care providers regarding proper and timely medical record documentation, including selection of the indicator boxes for SC and Agent Orange care.

Concur

**Target Completion Date:** 6/1/06

a. Completed. A process is in place to bill all 1st and 3rd party payors related to Non-VA care. We will continue to monitor to ensure 100% identification and billing.

b. Partially Completed. Training has been completed regarding the use of the indicator boxes for Agent Orange. A MCCR nurse is using QuadraMed to validate the Agent Orange designation before billing occurs. We have requested written direction from VACO Business Office and local compliance staff regarding proper selection of the indicator boxes for SC. We are planning additional education for medical care providers regarding proper and timely medical record documentation, as well as the selection of the SC indicator boxes.

**Recommendation 2.** We recommended that the VISN Director ensure that VISN Logistics staff and the Medical Center Director take steps to: (a) reduce supply inventory levels to meet the 30-day supply goal, (b) update GIP inventory records to match the actual quantities on hand, (c) secure office supplies storage, and (d) secure storage areas and update inventory records timely for prosthetic supplies.

Concur

**Target Completion Date:** 10/1/06

a. Completed. All supply inventory levels have been reviewed and adjusted, with the exception of items that the hospital requires to have stocked regardless of usage. The inventory levels for these items will be kept at the lowest level possible.

b. Completed. Items that were identified as having inaccurate quantities on hand were immediately corrected. A 100% physical inventory will be conducted annually.

c. To be completed. A wall will be constructed that will separate and secure these supplies in the warehouse.

d. To be completed. Prosthetics will secure internal and remote storage areas to limit access to authorized personnel only. Prosthetic staff will ensure timely recording of all stock issues from all areas.

Additional Action: Logistics will review the Automatic Level Setter Report on a quarterly basis, and the Stock Status Report monthly. Items will be stocked at the point of use if possible. Items will be deleted if they have little or no usage, (after consultation with the user).

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director emphasizes the need to (a) thoroughly review and follow up on outstanding obligations and (b) cancel those obligations that are no longer needed.

Concur

**Target Completion Date:** 7/1/06

a. A process has been established to review and follow-up on outstanding obligations with dedicated staff.

b. The dedicated staff in the above process are also responsible to clear obligations that are no longer needed, or to make final payment. This is done in concert with the appropriate control point official.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires that the Program Coordinator and Fiscal Officer: (a) audit cardholders' accounts quarterly as required, (b) reduce purchase card monthly credit and single purchase limits to match actual procurement needs, (c) ensure that cardholders adequately secure government purchase cards, and (d) separate duties so that approving officials do not both reconcile and certify the same transactions.

Concur

**Target Completion Date:** 9/30/06

a. In process. Currently, we are working on the backlog of audits; once this is finished, we will complete the audits quarterly.

b. In process. The monthly credit and purchase limits of the purchase cards will be reviewed and adjusted as appropriate to better match the actual procurement needs. This will be accomplished during the annual audit process.

c. Completed. Education has been provided for staff who did not secure government purchase cards. Locks have been installed to keep the cards secure.

d. Completed. Training has been provided and duties have been separated among staff so that one person does not reconcile and certify the same transactions.

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director requires (a) proper segregation of the duties for ordering and receiving pharmaceuticals when practical, or a process for monitoring of ordering/receiving be in place and (b) random scheduling of monthly, unannounced inspections of controlled substances.

Concur

**Target Completion Date:** Completed

a. Two technicians are utilized in the ordering and receiving process, so their activities are apparent to each other as well as others in the pharmacy. More random spot checks have been added on non-controlled medications to further minimize the opportunity for diversion.

b. The inspectors have been advised that monthly inspections do not have to be separated by two weeks. This has allowed for random scheduling of the monthly unannounced inspections.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the Patient Safety Coordinator complete the required RCAs, (b) responsible clinicians complete incident reports, (c) clinicians complete peer reviews in a timely manner, trend results, and meet quarterly as required, (d) the patient advocates perform more detailed patient complaint analyses, (e) the QM Coordinator trend and analyze morbidity and mortality data quarterly, and (f) responsible clinicians trend resuscitation events as required.

Concur

**Target Completion Date:** 5/1/06

a. In process. A tracking system for RCAs is in place. Several RCAs have been completed. Teams have been formed for the aggregate reviews of parasuicidal behaviors, falls, missing persons and medication errors, each with target dates for completion.

b. Completed. Education was done at clinical staff meetings regarding the importance of completing incident reports. Daily, all incident reports from the previous 24 hours are reviewed at Morning Report. The enhanced awareness has increased the number of incident reports received.

c. Completed. A tracking log for peer reviews is in place to monitor timeliness, trends and outcomes. The Patient Safety/Risk Management Committee has met twice since December, analyzing the data. Additionally, peer review activities are discussed weekly with the Chief of Staff.



d. In process. The Patient Advocate Manager expanded the program to include managers/supervisors as Patient Advocates. Training for the new advocates was completed in October 2005. Complaints are now tracked, trended and reported to the Quality and Performance Council. The Patient Advocate Manager is in the process of "drilling down" first quarter FY 06 data for the top three complaints to identify areas needing improvement. A comprehensive report of the findings will be provided to the Patient Advocates, Senior Managers and Service Directors to share with staff.

e. Completed. Mortality reviews have been trended, analyzed and reported to the Quality and Performance Council. Morbidity reviews have been trended, analyzed and are reported through the peer review and surgical risk review systems.

f. In process. A tool has been developed that incorporates specifics such as area, shift, day of the week, practitioner, time and outcome. We are in the process of reviewing resuscitation events since the beginning of FY 06 utilizing this new tool. The information will be trended and reported monthly to the Critical Care Committee and quarterly to the Clinical Practice Council.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 working days and (b) document the communication in the medical record.

Concur

**Target Completion Date:** Completed

a. and b. Currently the vendor is notifying the VAMC the same day for suspicious/abnormal mammograms. The issue is that we haven't been documenting this notification. The ordering provider is now entering an administrative note into CPRS the same day they receive the notification from the vendor, as well as arranging for the appropriate follow-up.

## Monetary Benefits in Accordance with IG Act Amendments

<b><u>Recommendation</u></b>	<b><u>Explanation of Benefit(s)</u></b>	<b><u>Better Use of Funds</u></b>
1	Enhancing MCCF billings and collections.	\$44,792
2	Reducing supply inventories to 30-day levels.	43,880
3	Canceling unneeded obligations.	18,945
	Total	\$107,617

## OIG Contact and Staff Acknowledgments

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