Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, Texas

Report No. 06-00661-175 **July 24, 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 January 9–13, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the West Texas VA Health Care System, Big Spring, TX. 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 220 employees. The health care system is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

The CAP review focused on 11 areas. The health care system complied with selected standards in the following areas:

- Accounts Payable
- All Employee Survey
- Contract Administration
- Environment of Care
- Quality Management

To improve operations, the following recommendations were made:

- Reduce waiting times for breast biopsies and communication of their results.
- Increase Medical Care Collections Fund (MCCF) collections by obtaining insurance information and improving billing procedures.
- Strengthen supply inventory management and reduce stock levels.
- Improve timeliness of MCCF accounts receivable follow-up.
- Strengthen information technology (IT) security by disabling inactive accounts.
- Obtain warrants for approving officials who monitor warranted purchase cardholders.

This report was prepared under the direction of Mr. Michael Guier, Director, and Ms. Patricia Conliss, CAP Review Coordinator, Dallas Audit Operations Division.

VISN 18 and Health Care System Director Comments

The VISN 18 and Health Care System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 12–21 for the full text of the Directors' comments.) We will follow up on the implementation of reported and planned improvement actions.

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

Introduction

Health Care System Profile

Organization. The health care system provides inpatient and outpatient health care services in Big Spring, TX. Outpatient care is also provided at six community-based outpatient clinics located in Abilene, Fort Stockton, Odessa, San Angelo, and Stamford, TX, and Hobbs, NM. The health care system is part of VISN 18 and serves a veteran population of about 67,000 residing in 47 counties in west Texas and New Mexico.

Programs. The health care system provides primary care, medical, surgical, and psychiatric services as well as extended geriatric care. It also offers rehabilitation, oncology, and dental services. As of September 30, 2005, the health care system had 65 operating beds, including 25 acute and intermediate care beds and 40 nursing home care beds.

Affiliations and Research. The health care system is affiliated with the Texas Tech University Health Sciences Center for ophthalmology services. It also has affiliations with nine other institutions providing clinical training opportunities in nursing, phlebotomy, and dental hygiene. The health care system does not have a research program.

Resources. In fiscal year (FY) 2005, the health care system's medical care expenditures totaled $68.8 million. The FY 2006 medical care budget was $70.8 million. In FY 2005, the health care system had 477 full-time equivalent employees (FTE), which included 27 physician FTE and 71 nursing FTE.

Workload. The health care system treated 17,297 unique patients in FY 2005. Inpatient workload totaled 1,052 discharges in FY 2004 and 1,222 discharges in FY 2005. The average daily patient census in FY 2005 was 15 for acute and intermediate care and 34 for nursing home care. The outpatient workload totaled 135,976 visits in FY 2004 and 155,135 visits in FY 2005.

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. 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. 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 health care system operations for FYs 2004 and 2005 and FY 2006 through January 12, 2006, 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 activities:

Accounts Payable	Government Purchase Card Program
Accounts Receivable	Information Technology Security
All Employee Survey	Medical Care Collections Fund
Breast Cancer Management	Quality Management
Contract Administration	Supply Inventory Management
Environment of Care	

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

We also presented four fraud and integrity awareness training sessions for health care system employees. A total of 220 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 activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Follow-Up on Prior CAP Review Recommendations

As part of our review, we followed up on the recommendations resulting from our prior CAP review of the health care system (*Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas,* Report No. 04-02293-73, January 28, 2005). In the report, we made recommendations to improve controls over supply inventory management, MCCF, IT security, controlled substances accountability, service contracts, and purchase cards. During this CAP review, we determined that the health care system continues to need improvement in the areas of supply inventory management, MCCF, IT security, and purchase cards.

Results of Review

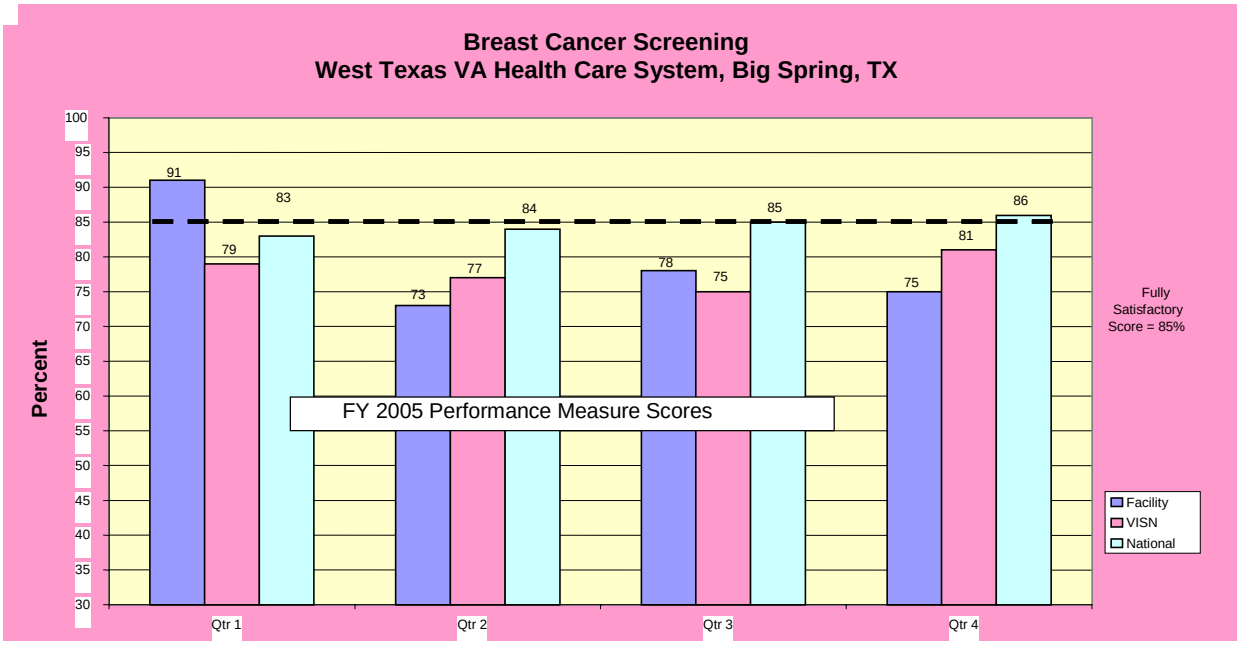
Opportunities for Improvement

Breast Cancer Management – Waiting Times for Biopsies and Communication of Results Needed Improvement

Condition Needing Improvement. Clinicians needed to improve the timeliness of breast cancer diagnoses by reducing waiting times for breast biopsies and their results. Because the health care system does not have mammography or other breast care related capabilities, these services are offered to patients through fee-basis providers. During FY 2005, the health care system reported 151 fee-basis mammograms. Consultations and referrals for breast care were requested in a timely manner. However, the coordination of interfacility treatment plans, including the communication of results to patients and documentation of these communications, needed improvement.

Criteria. The Veterans Health Administration (VHA) breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. To be fully satisfactory, facilities must screen at least 85 percent of the eligible patients within the prescribed timeframes. VHA mammography standards require that normal findings be documented in the medical record within 30 days of the procedures. However, suspicious or abnormal results must be communicated to the patient as soon as possible and can ordinarily be accomplished within 5 working days. Although communication may be verbal, all communication must be documented in the patient's medical record, and timely results need to be available and accessible to guide patient care and treatment. Timely screening and diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes.

Findings. The health care system did not meet the VHA goal for breast cancer screenings for 3 of the 4 quarters of FY 2005, as shown in the chart on the following page:



We assessed the care provided to five randomly selected patients who were diagnosed with breast cancer or had suspicious or highly suggestive mammogram results during FYs 2004 and 2005 and found that all five were appropriately screened. However, in one of the five cases, results were not reported to the patient within 30 days. In two of the five cases, the patients were not appropriately notified of their diagnoses. In two of the five cases, patients did not receive timely consultations, and, in two of three cases, the biopsies were not performed timely. Positive results are summarized in the chart below:

Patients appropriately screened	Mammography results reported to patients within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedures
5/5	**4/5**	**3/5**	**3/5**	**1/3**

Cause. Low scores in VHA breast cancer screening performance measures may be skewed by the diversity of fee-basis providers and the difficulty in obtaining reports from fee-basis providers. Identified obstacles include:

- Patient notification of mammography results for suspicious or highly suggestive reports does not consistently occur within 5 days.
- Biopsy procedures are frequently delayed due to a lack of coordination between health care providers and/or patient requests to reschedule.
- There is no process for timely placement of diagnostic reports in the medical record.

The current fee-basis agreement does not include a requirement for outside facilities to schedule procedures or to report the results of mammograms within the timeframes specified by VHA.

Recommendation 1. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) notify patients of test results within 5 days if the results are suspicious or highly suggestive, (b) reduce the waiting time from mammography results to biopsy procedures, (c) document patient notification and place mammography reports into the medical records in a timely and consistent manner, and (d) incorporate VHA requirements for mammogram scheduling and reporting into contracts or sharing agreements with fee-basis providers.

The VISN and Health Care System Directors agreed with the findings and recommendations. They reported that the health care system's Women Veterans Coordinator is now receiving suspicious or highly suggestive mammogram results and notifying both the primary care provider and the patient the same day the results are received. All contacts are documented in the medical records. New processes for referral, reporting, documentation, and notification of results are being outlined to reduce waiting times. In addition, the health care system has issued an amendment to the contract outlining scheduling and reporting requirements. The improvement plans are acceptable, and we will follow up on reported implementation actions to ensure they are completed.

Medical Care Collections Fund – Collections from Insurance Carriers Could Be Increased

Condition Needing Improvement. The health care system could increase MCCF collections by obtaining insurance information from veterans at the time of treatment and ensuring MCCF personnel identify all billable care. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. In FY 2004, the health care system collected $4.6 million, which exceeded its FY 2004 collection goal of $3.2 million. In FY 2005, the health care system collected $4.6 million, which was 98 percent of its FY 2005 collection goal of $4.7 million.

Insurance Information. Health care system managers needed to ensure that eligibility and clinic clerks obtain insurance information from veterans at the time of treatment so that MCCF personnel could bill insurance carriers promptly. VHA policy stresses the importance of insurance identification, as well as billing and collections, in generating revenue. The health care system's "Detailed Patients with Unidentified Insurance Report" for the period July 1 through September 30, 2005, listed 50 veterans who had been treated in the fourth quarter of FY 2005 but had no secondary insurance listed. We reviewed patient information recorded in the Veterans Health Information Systems and Technology Architecture system for 10 of the 50 veterans and found that health care

system personnel had not obtained insurance information for any of the 10 veterans even though they had been treated at least 3 months prior to our review. During our review, MCCF personnel obtained insurance information for 6 of the 10 veterans and verified that 3 had secondary insurance and 3 did not. They sent letters requesting insurance information for the remaining four veterans.

For two of the three veterans with secondary insurance, their episodes of care were not billable because they were either treated for service-connected conditions or were provided care that was not billable under the terms of the insurance plans**.** For the one remaining veteran, we identified two episodes of care that resulted in four missed billing opportunities totaling $8,784. When we brought the missed billing opportunities to the attention of MCCF personnel, they submitted four bills to the insurance carrier.

Identification of Billable VA Care. We reviewed 10 episodes of care totaling $12,043 from the "Unbilled Amounts Detail Report" for the period April 1 through September 30, 2005. We identified 4 episodes of care with 14 missed billing opportunities totaling $36,646. MCCF personnel told us that the billing opportunities were missed because they had not had time to regularly follow up on the "Unbilled Amounts Detail Report" or because coders had mistakenly determined that the episodes of care were not billable. As a result of our review, MCCF personnel issued 14 bills for the missed billing opportunities we identified.

Billable Fee-Basis Care. From July 1 through September 30, 2005, the health care system paid 346 fee-basis claims totaling $83,468 to non-VA clinicians for the care of veterans with health insurance. To determine if the health care system had billed the insurance carriers for this care, we reviewed 30 fee-basis claims totaling $63,837. Our review found that 26 fee-basis claims were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions, the veterans did not have insurance coverage on the dates of the care, or the care provided was not billable under the terms of the insurance plans. The remaining four fee-basis claims totaling $13,424 should have been billed.

- In two cases, MCCF personnel did not contact the veterans' insurance companies to determine if they would pay for the veterans' nursing home care. These two cases resulted in three missed billing opportunities totaling $5,747.
- In two cases, MCCF personnel overlooked the episodes of care. These two cases resulted in two missed billing opportunities totaling $7,677.

As a result of our review, MCCF staff issued five bills totaling $13,424 for the four fee-basis claims we identified.

Additional Collections. Obtaining insurance information promptly, identifying all billable VA care, and properly billing insurance companies for fee-basis care will enhance MCCF revenue collections. We estimated that additional billings totaling

$58,854 ($8,784 + $36,646 + $13,424) could have been issued for the missed billing opportunities we identified. Based on the health care system's historical collection rate of 36.9 percent, MCCF personnel could have increased collections by $21,717 ($58,854 x 36.9 percent). As a result of our review, MCCF personnel issued 23 bills for the missed billing opportunities we identified.

Recommendation 2. We recommended the VISN Director ensure that the Health Care System Director requires that: (a) eligibility and clinic clerks obtain insurance information at the time of treatment, (b) MCCF personnel identify and bill all billable VA care, and (c) MCCF personnel identify and bill all billable fee-basis care.

The VISN and Health Care System Directors agreed with the findings and recommendations. Eligibility and clinic clerks have been instructed to obtain insurance information when patients present, and this requirement has been added to the clerks' performance plans. In November 2005, the health care system installed new coding and billing software that identifies potential billing opportunities, and MCCF personnel will review reports generated by this software more frequently. Also, MCCF personnel are now manually checking all fee-basis claims to identify billable episodes of care. The improvement plans are acceptable, and we will follow up on reported implementation actions to ensure they are completed.

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

Condition Needing Improvement. The health care system needed to maintain accurate inventory records and reduce stock levels of supplies. VHA policy 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 health care system's supply inventory included 1,164 line items valued at $92,107.

Inaccurate Inventory Records. The health care system was not maintaining accurate inventory records. To assess the accuracy of GIP and PIP data, we inventoried 20 medical, 12 engineering, and 15 prosthetics line items with a combined recorded value of $13,494. The stock levels recorded in GIP and PIP were inaccurate for 20 (43 percent) of the 47 line items, with 10 shortages valued at $897 and 10 overages valued at $1,616. The actual value of the 47 line items inventoried totaled $14,213, which was 5 percent higher than the recorded value. Applying this 5 percent difference to the total inventory, the restated value of the health care system's supply inventory would be $96,712 ($92,107 x 1.05). The inaccurate inventory records occurred primarily because health care system personnel did not promptly record receipts and distributions of supplies. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. The health care system needed to reduce stock levels of supplies. To determine if stock levels could be reduced while still meeting the health care system's

needs, we compared the quantities on hand to usage data for the 47 line items that we inventoried. We found that the health care system needed to reduce stock levels for 9 (19 percent) of the 47 line items. The value of the excess stock was $1,183, which was about 8 percent of the actual value ($14,213) of the 47 line items we inventoried. Based on the restated value of inventory of $96,712, the estimated value of excess stock was $7,737 ($96,712 x 8 percent). Overstocking ties up money in stock and increases the risk of damage, outdating, contamination, or obsolescence of inventory items.

Recommendation 3. We recommended that the VISN Director ensure the Health Care System Director takes action to (a) reconcile differences and correct inventory records as appropriate and (b) reduce stock levels to the minimum needed to meet the health care system's needs.

The VISN and Health Care System Directors agreed with the findings and recommendations and noted that the deficiencies we identified were all in Prosthetics and Engineering Services. The Chief, Acquisition and Materiel Management Service, and Prosthetics Service personnel conducted a wall-to-wall inventory of prosthetics items and made the necessary adjustments to inventory records. To improve inventory management in Prosthetics Service, stock status will be monitored monthly and an inventory will be conducted quarterly. In Engineering Service, stock levels will be monitored and random line items will be audited monthly, and a new primary inventory area will be established. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Follow-Up Needed To Be Timely

Condition Needing Improvement. Fiscal Service personnel established and reconciled MCCF accounts receivable in accordance with VA policy. However, follow-up on outstanding MCCF accounts receivable was not timely.

VA policy requires prompt and aggressive follow-up action to collect accounts receivable and establishes uniform follow-up procedures. For MCCF accounts receivable, the first follow-up telephone call is to take place 30 days after the bill is issued, with additional follow-up calls no later than 21 days and then 14 days thereafter if no payment has been received. As of December 6, 2005, the health care system had 16,711 outstanding MCCF accounts receivable totaling $1.8 million that were at least 1 year old. We reviewed five MCCF accounts receivable totaling $112,410 and found that Fiscal Service personnel were late in making follow-up calls in all five cases. First follow-up calls were an average of 34 days late, second follow-up calls an average of 183 days late, and third follow-up calls an average of 92 days late. Timely follow-ups would increase the probability that accounts receivable would be collected.

Recommendation 4. We recommended that the VISN Director ensure that the Health Care System Director takes action to pursue delinquent MCCF accounts receivable in accordance with VA policy.

The VISN and Health Care System Directors agreed with the findings and recommendation. They stated that one accounts receivable technician has been dedicated to following up on outstanding MCCF accounts receivable, and weekly audits will be conducted to monitor the timeliness of follow-up calls. They reported that, as of April 25, 2006, there were only 88 outstanding accounts receivable totaling $8,121 that were over 1 year old. The improvement plans are acceptable, and we will follow up on reported implementation actions to ensure they are completed.

Information Technology Security – Inactive Accounts Needed To Be Disabled

Condition Needing Improvement. To follow up on recommendations from the previous CAP review, we reviewed the health care system's contingency plan and IT system inactive accounts. The health care system's contingency plan had been revised to include a list of IT equipment needed to support critical IT system functions as recommended. However, the health care system still needed improvement in identifying and disabling inactive accounts.

The Information Security Officer (ISO) did not ensure that inactive accounts were disabled in a timely manner. VHA policy requires ISOs to review user access at least every 90 days to ensure that levels of access are appropriate and that continued access is needed. VHA policy also requires health care system personnel to disable accounts that have been inactive for 90 days. We identified 23 accounts that were inactive for at least 90 days prior to November 30, 2005. At the time of our review, 19 (83 percent) of the 23 inactive accounts had not been disabled. Health care system officials told us that the accounts had not been disabled because the program used to identify inactive accounts was not configured properly. During our review, health care system personnel reconfigured the program and the 19 accounts were properly disabled.

Recommendation 5. We recommended that the VISN Director ensure that the Health Care System Director takes action to identify and disable all inactive accounts in a timely manner.

The VISN and Health Care System Directors agreed with the findings and recommendation. Health care system personnel determined that the report used nationally to identify inactive accounts was not identifying the inactive accounts of non-employee users with remote access. They corrected the problem locally and disabled the inactive users' accounts. The ISO will continue to monitor inactive accounts monthly. The improvement plans are acceptable, and the 19 accounts were disabled; therefore, the recommendation will be closed.

Government Purchase Card Program – Approving Officials Needed To Be Warranted

Condition Needing Improvement. The health care system needed to ensure that approving officials have the appropriate warrants to monitor their warranted cardholders. VHA policy requires that approving officials for warranted cardholders be warranted at the same level or higher to ensure they have adequate knowledge of the VA Acquisition Regulation and the Federal Acquisition Regulation to properly monitor their cardholders. Of the health care system's 11 approving officials, 3 monitored warranted cardholders. We found that two of the three approving officials did not have warrants. The requirement to have the approving officials warranted was added in 2005, and the Purchase Card Coordinator told us that the approving officials had not yet taken the training needed to obtain the appropriate warrants.

Recommendation 6. We recommended that the VISN Director ensure the Health Care System Director requires that approving officials obtain warrants at the same levels as, or higher levels than, the warranted cardholders they monitor.

The VISN and Health Care System Directors agreed with the findings and recommendation. They reported that the two approving officials have received appropriate training and will be properly warranted by May 31, 2006. In the interim, the purchase cardholders were temporarily reassigned to other warranted approving officials. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 18 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2006

From: Director, VISN 18

Subject: **West Texas VA Health Care System, Big Spring, Texas**

To: Director, Dallas Audit Operations Division

I concur with the attached facility update on the recommendations for improvement contained in the Combined Assessment Program review at the West Texas VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A. McKlem

Attachment

cc: Margaret Seleski, Director, Management Review Service (10B5)

Director 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 Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) notify patients of test results within 5 days if the results are suspicious or highly suggestive, (b) reduce the waiting time from mammography results to biopsy procedures, (c) document patient notification and place mammography reports into the medical records in a timely and consistent manner, and (d) incorporate VHA requirements for mammogram scheduling and reporting into contracts or sharing agreements with fee-basis providers.

Concur **Target Completion Date:** 5/31/2006

See facility Director comments

Recommendation 2. We recommend the VISN Director ensure that the Health Care System Director requires that: (a) eligibility and clinic clerks obtain insurance information at the time of treatment; (b) MCCF personnel identify and bill all billable VA care, and (c) MCCF personnel identify and bill all billable fee-basis care.

Concur **Target Completion Date:** 6/30/2006

See facility Director comments

Recommendation 3. We recommend that the VISN Director ensure the Health Care System Director takes action to (a) reconcile differences and correct inventory records as appropriate and (b) reduce stock levels to the minimum needed to meet the health care system's needs.

Concur **Target Completion Date:** 7/31/2006

See facility Director comments

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director takes action to pursue delinquent MCCF accounts receivable in accordance with VA policy.

Concur **Target Completion Date:** 4/30/2006

See facility Director comments

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director takes action to identify and disable all inactive accounts in a timely manner.

Concur **Target Completion Date:** 1/12/2006

See facility Director comments

Recommendation 6. We recommend that the VISN Director ensure the Health Care System Director requires that approving officials obtain warrants at the same levels as, or higher levels than, the warranted cardholders they monitor.

Concur **Target Completion Date:** 7/31/2006

See facility Director comments

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 25, 2006

From: Director, West Texas VA Health Care System

Subject: **West Texas VA Health Care System, Big Spring, Texas**

To: Director, Dallas Audit Operations Division

I would like to thank the OIG CAP Survey Team for their professional, comprehensive, impartial and educational survey January 9-13, 2006. I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of the West Texas VA Health Care System (WTVAHCS). I concur with the findings needing improvement and recommendations for improvement actions. Many of the corrective actions are either complete or near completion.

I am very pleased with the positive comments made by the reviewers during the exit briefings, which provided affirmative feedback to staff on the progress this facility has made. These included no findings in several areas: Medical (SPD) inventory; Pharmacy inventories and controlled substance reports; Accounts Payable; Quality Management; Environments of Care; the All Employee Survey; and Health Care Services. Two areas were described as very effective programs: the Government Purchase Card program and Quality Management. The reviewers stated that the Big Spring facility was a 50-year old building in outstanding condition. the WTVAHCS staff is very proud of the results of the patients surveyed by the OIG and the overall ratings provided.

Again, I thank the OIG Team for their comprehensive survey. The collective efforts and expertise of the CAP review team promotes continuous improvement and raises

the level of care, safety, and service provided to our nation's heroes, the veterans.

(original signed by:)

LOU ANN ATKINS, MSN, MBA, CHE

Director

Director 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 Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) notify patients of test results within 5 days if the results are suspicious or highly suggestive, (b) reduce the waiting time from mammography results to biopsy procedures, (c) document patient notification and place mammography reports into the medical records in a timely and consistent manner, and (d) incorporate requirements for mammogram scheduling and reporting into contracts or sharing agreements with fee-basis providers.

Concur **Target Completion Date:** 5/31/2006

a., c., and d. The WTVAHCS has initiated a process to ensure timely notification of mammogram results, both significant and normal. Agreements have been developed with the mammography center, with which WTVAHCS has contracts. As soon as type 4 and 5 findings are identified, the contractor contacts the Women Veterans Coordinator, who then notifies the primary care provider and the patient the same day the report is received. All contacts are documented in the patient record. Since this process was initiated in February 2006, three type 4 cases have been identified. In all three cases, the WTVAHCS was contacted immediately and the patients were notified on the same day. For normal results, the facility sends a letter to the patient as soon as receiving the report from the contractor. Data is tracked by the Women Veterans Coordinator and reported to the Women Veterans subcommittee of the Clinical Executive Board.

An amendment to the contract has been issued to the contractor outlining the requirements for scheduling and reporting. This amendment is located in the contract file.

b. The facility is outlining processes for referral, reporting, documentation, and notification of biopsy procedures. The new process to reduce the waiting time will be in place by May 31, 2006. In the interim, the Women Veterans Coordinator is overseeing expeditious management of biopsy referrals.

Recommendation 2. We recommend the VISN Director ensure that the Health Care System Director requires that: (a) eligibility and clinic clerks obtain insurance information at the time of treatment; (b) MCCF personnel identify and bill all billable VA care, and (c) MCCF personnel identify and bill all billable fee-basis care.

Concur **Target Completion Date:** 6/30/2006

a. Eligibility and clinic clerks have been instructed to obtain copies of insurance cards at the time the patient presents. This requirement has been added to the performance plans for these staff. The target is that 70% copying of insurance cards will occur by December 31, 2006. Health Administration Service (HAS) is reporting the number of copies made daily in management's morning report. Weekly tracking and trending has been initiated for monthly reporting to Business Office subcommittee of the Resources Board and to Leadership Board.

b. The QuadraMed billing/coding software was installed at this facility in November 2005. This software identifies all potential billing opportunities. Currently, MCCF is running the Code Me Report, which identifies potential billing episodes, on a weekly basis. The Bill Me Report, which shows all coded episodes, is run monthly. As a monitor, the Unbilled Report, which captures any missed billing episodes, is being run and reported monthly to Business Office and Leadership.

Once two vacant billing positions are filled, we will begin running the Code Me and Bill Me reports on a daily basis. A list of applicants has been received for these positions and selections will be made by May 12, 2006. The target date for beginning new reporting process is June 30, 2006.

c. The process for managing fee basis bills has been modified. Fee basis submits all batches to Fiscal Service for transmission to Austin and auditing. Fiscal Service forwards all batches to MCCF where each batch is manually checked for billable episodes. MCCF has initiated a monthly random audit of fee basis bills to validate billing accuracy. These audits will be reported at Business Office and Leadership Board.

Recommendation 3. We recommend that the VISN Director ensure the Health Care System Director takes action to (a) reconcile differences and correct inventory records as appropriate and (b) reduce stock levels to the minimum needed to meet the health care system's needs.

Concur **Target Completion Date:** 7/31/2006

During the site visit, the reviewers examined three areas: Medical, Engineering, and Prosthetics. Medical (SPD) was an area of recommendation from the previous IG-CAP review 18 months earlier. Since that review, the WTVAHCS has taken aggressive action to address this area. Excess stock levels have been reduced and the current visit resulted in no findings.

Prosthetics - At the time of the review of the Prosthetics inventory, the clerk had just received a shipment of prosthetic items. While these had been logged into the inventory package, they had not yet been shelved, creating a discrepancy in the review. The reviewer discussed enhancements to current inventory processes with the Chiefs of Prosthetics and A&MMS while on site. As a result, the Chief, A&MMS, with Prosthetics staff, conducted a wall to wall inventory of this area to ensure accurate documentation in the inventory package. The following monitors have been established for prosthetics: a Stock Status Report will be run monthly and a quarterly inventory will be completed.

Engineering - During the site visit, the Chief A&MMS discussed the facility plan to create a new primary inventory area, a "parts department", for Engineering. In the exit interview, the reviewer acknowledged that the facility had an appropriate plan in place to address this issue. This plan will be fully implemented by July 31, 2006. Monthly monitoring will include an evaluation of the Availability and Stock On-hand report and an audit of random line items.

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director takes action to pursue delinquent MCCF accounts receivable in accordance with VA policy.

Concur **Target Completion Date:** 4/30/2006

MCCF has implemented the guidance received from the Office of Finance for follow-up of outstanding accounts. One Accounts Receivable tech has been dedicated to aggressively pursuing claims under the timelines outlined in OF Bulletin 06GC1.04, dated February 10, 2006. As of December 6, 2005, there were 16,711 outstanding accounts greater than 1 year old, totaling $1.8 million. As of April 25, 2006, the Third Party Follow-up Summary Report shows 88 bills totaling $8,121.49 over 365 days. The WTVAHCS will conduct weekly random audits of accounts receivable to monitor the timeliness of follow-up calls. The results of the audits, along with tracking of accounts receivable by age, will be reported at the Business Office subcommittee of the Resource Board and to leadership.

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director takes action to identify and disable all inactive accounts in a timely manner.

Concur **Target Completion Date:** 1/12/2006

The West Texas VA Health Care System has had a plan in place to review inactive users every 30 days since the previous IG-CAP visit. However, during the current site visit, it was noted that non-employee users (those that obtained access by utilizing options such as remote data view and PDX) were not being discontinued as required. A NOIS was

logged during the site visit and it was identified that the report being generated was not functioning appropriately on a national level. The facility corrected the functionality locally and appropriately disabled the inactive accounts while the reviewer was on site. The Information Security Officer monitors the inactive users on a monthly basis. We recommend closure of this item.

Recommendation 6. We recommend that the VISN Director ensure the Health Care System Director requires that approving officials obtain warrants at the same levels as, or higher levels than, the warranted cardholders they monitor.

Concur **Target Completion Date:** 7/31/2006

The review identified two approving officials that did not have warrants that were at the same level, or higher, than those of the cardholders they monitored. The requirement for this higher level warrant, which was added in 2005, is new. Both approving officials have received appropriate training and the warrants will be issued by May 31, 2006. In the interim, these cardholders have been placed under other warranted individuals at the WTVAHCS.

It should be noted that during the exit interview, the team leader stated that the purchase card program reviewer found the program at the West Texas VA Health Care System to be one of the best that she had ever reviewed. The reviewer concurred with this statement.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	$21,717
3	Reducing stock levels would make funds available for other uses.	7,737
	Total	$29,454

Appendix D

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Appendix E

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