Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Black Hills Health Care System South Dakota

Report No. 06-00635-234

September 29, 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 April 17–21, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Black Hills Health Care System (referred to as the system), which is part of Veterans Integrated Service Network (VISN) 23. 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 67 employees.

Results of Review

The CAP review covered 14 operational activities. The system complied with selected standards in the following eight activities:

- Agent Cashier
- All Employee Survey
- Breast Cancer Management
- Community Contract Nursing Home
- Controlled Substances Accountability
- Environment of Care
- Information Technology Security
- Service Contracts

We made recommendations in 6 of the 14 activities reviewed. For these activities, the medical center needed to:

- Improve Medical Care Collections Fund (MCCF) billing procedures and ensure clinicians adequately document provided care.
- Improve the accuracy of medical supply inventory records.
- Strengthen inventory procedures and controls over nonexpendable equipment.
- Improve controls over the Government Purchase Card Program.
- Enhance diabetic care by managing laboratory values and nutritional consults.
- Strengthen QM data analysis and reporting processes.

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 23 and System Director Comments

The VISN and System Directors agreed with all recommendations and provided acceptable improvement plans (see Appendixes A and B, pages 11–18, for the full text of the Directors' comments). We will follow up on the implementation of planned improvement actions.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

System Profile

Organization. The system provides a broad range of inpatient and outpatient services at its Fort Meade and Hot Springs, SD facilities. Outpatient care is provided at 11 community-based clinics located in South Dakota, Nebraska, and Wyoming. The system is part of VISN 23 and services a veteran population of about 38,000 in a primary service area that includes 32 counties in South Dakota, 7 counties in Nebraska, 3 counties in North Dakota, and 3 counties in Wyoming.

Programs. The system provides medical, surgical, psychiatric, domiciliary, and nursing home care. The system has 60 hospital beds, 104 nursing home beds, and 160 domiciliary beds. The system has sharing agreements with Ellsworth Air Force Base, South Dakota Army National Guard, and other community partners.

Affiliations and Research. The system has an active affiliation with the University of South Dakota Medical School. The system provides training for two podiatry residents and has affiliations with other allied health disciplines. For fiscal year (FY) 2005, the research program had nine active projects and a budget of $7,262.

Resources. In FY 2005, the system's medical care expenditures totaled $122 million. FY 2005 staffing was 953 full-time equivalent employees (FTE), including 36 physician and 248 nursing FTE.

Workload. In FY 2005 the system treated 20,724 unique patients, a 1.3 percent increase over FY 2004. The FY 2005 inpatient care workload totaled 2,375 discharges with an average daily census (ADC) of 30. The ADC was 76 for the nursing home and 105 for the domiciliary. The outpatient workload was 232,369 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, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and 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 14 activities:

- Agent Cashier
- All Employee Survey
- Breast Cancer Management
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Medical Care Collections Fund
- Quality Management
- Service Contracts
- Supply Inventory Management

The review covered facility operations from FY 2004 through March 31, 2006, 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 system (*Combined Assessment Program Review of the VA Black Hills Health Care System*, Report No. 03-02996-94, March 1, 2004).

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. These issues are discussed in the Opportunities for Improvement section (pages 3–9). 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 – Fee-Basis Billing Procedures and Clinical Documentation Needed Improvement

Condition Needing Improvement. The Business Office Manager could increase collections by improving billing procedures and ensuring clinicians adequately document provided care. During FY 2005, the system collected $7.4 million (91 percent of the healthcare system's collection goal of $8.1 million). We identified two areas that needed improvement.

Fee-Basis. From October 2005–December 2005, the system paid non-VA clinicians $285,747 for 1,978 fee-basis encounters for veterans with health insurance. To determine if the system identified and billed the veterans' insurance carriers for this care, we randomly sampled 196 fee-basis encounters valued at $128,548. Ninety-five of 196 fee-basis encounters had been billed promptly. Seventy-four of the remaining 101 fee-basis encounters were not billable to the insurance carriers because the insurance coverage had expired before the date of the fee-basis encounter, the fee-basis encounter was for service-connected conditions, or the care provided during the fee-basis encounter was not billable under the terms of the insurance policy. For the remaining 27 fee-basis encounters that were billable, MCCF staff had not issued bills because of an oversight and other work priorities. MCCF staff issued bills totaling $65,606 for the 27 fee-basis encounters during the CAP review.

Clinical Documentation. The MCCF "Reasons Not Billable (RNB) Report" for the period October 2004–December 2005 listed 343 fee-basis encounters totaling $64,517 that were not billed due to one of the following reasons: (1) insufficient documentation, (2) no documentation, or (3) non-billable provider. We reviewed a random sample of 50 potentially billable encounters from the RNB report, totaling $1,762. Twenty-seven of the 50 (54 percent) encounters valued at $573 were not properly identified as billable encounters because the MCCF coders did not assign the correct RNB code. In addition, 23 of the 50 (46 percent) encounters valued at $1,189 had not been billed due to insufficient or no documentation. MCCF staff did not follow up with clinicians when clinical documentation was insufficient or missing.

Potential Collections. Improved billing procedures for fee-basis care and better clinical documentation would increase revenue collections. We estimated that additional billings totaling $67,368 ($65,606 + $573 + $1,189) could have been achieved. Based on the system's FY 2005 collection rate of 33.4 percent, we estimate additional collections totaling $22,501 ($67,368 x 33.4 percent) could have been achieved.

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that: (a) the Business Office Manager ensures all potentially billable fee-basis encounters are billed, (b) the Business Office Manager provides training on the correct use of RNB codes, (c) the MCCF staff reviews the RNB report for the period October 2004–December 2005 to identify any potentially billable encounters which were miscoded, (d) clinicians adequately document care provided to patients, and (e) the MCCF staff follow up with clinicians as needed to ensure sufficient documentation is obtained.

The VISN and System Directors agreed with the findings and recommendations. They reported that a standard operating procedure will be implemented to define the process for insufficient documentation of billable visits. The Business Office Manager trained business office staff on RNB codes and will review the RNB report monthly with the Compliance Officer. An audit of RNB is still in progress. A new Coder Educator position was established and that person interacts with the medical staff regarding documentation and coding requirements. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Accuracy of Inventory Records Needed Improvement

Condition Needing Improvement. System supply management staff did not maintain accurate medical supply inventory records. Veterans Health Administration (VHA) policy establishes a 30-day supply goal and requires staff to use the automated Generic Inventory Package (GIP) to manage inventories of medical supply inventories. At the time of our review, the system had 2,055 line items valued at $333,952. We selected a sample of 20 line items valued at $13,579 and compared actual stock on hand to the quantities reported in GIP inventory records to determine the accuracy of GIP records. Of these 20 items, we found that the GIP records for 12 (60 percent) of the 20 items were inaccurate. The inaccuracies in the data occurred because inventory transactions were not always correctly or completely posted in GIP. For example, GIP inventory records indicated that one line item had stock on hand valued at $3,598. However, none were located in the inventory storage area. A GIP responsible official did not have an explanation for why there was a difference between the GIP records and the actual quantity on hand. The inaccuracies in the GIP medical supply inventory data prevented us from assessing the system's compliance with VHA's 30-day supply goal.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires supply management staff to ensure the accuracy of GIP medical supply inventory records.

The VISN and System Directors agreed with the findings and recommendations. The Logistics staff have implemented a process to monitor GIP inventories in all departments. They have provided GIP training sessions to inventory users and managers. Logistics

staff will continue to monitor and make recommendations on all GIP inventories. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Condition Needing Improvement. The Logistics Service Chief needed to improve controls over nonexpendable equipment (items costing more than $5,000 with an expected useful life of 2 years or more) and sensitive equipment. VA policy requires the completion of physical inventories to ensure equipment is properly accounted for and recorded on Equipment Inventory Lists (EILs). As of December 31, 2005, the system had 99 EILs containing 1,001 items valued at $22.1 million. We identified two areas that needed improvement.

EIL Inventories. VA policy requires responsible officials to complete EIL inventories within 10 days of notification (20 days if the EIL contains 100 or more items). During FYs 2004–2005, responsible officials did not complete 46 required EIL inventories for 548 equipment items valued at about $10.6 million. According to the Logistics Service Chief, the person responsible for ensuring the completion of the EIL inventories did not monitor operations closely and enforce VA policy.

Quarterly Spot Checks. VA policy requires the Logistics Service Chief to conduct quarterly spot checks of all EILs to verify inventory accuracy. During FYs 2004–2005, no quarterly spot checks were performed. In FY 2006, Logistics Service staff only performed spot checks for 2 of the 4 quarters. The Logistics Service Chief stated that all of the required spot checks were not completed for FY 2006 due to an oversight.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires the Logistics Service Chief to (a) ensure responsible staff complete required EIL inventories within established time frames and (b) conduct quarterly spot checks of EILs to verify inventory accuracy.

The VISN and System Directors agreed with the findings and recommendations. The Logistics staff will monitor EIL inventories for timely completion and send reports to the System Director. Quarterly spot checks of EILs have been conducted since October 1, 2005. The implementation plans are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Internal Controls Needed To Be Strengthened

Condition Needing Improvement. The system needed to improve controls over the Government Purchase Card Program. As of December 31, 2005, 98 cardholders were responsible for 130 accounts. During the 15-month period ending December 31, 2005,

the system's cardholders made 25,926 transactions valued at $11.5 million. We identified two areas that needed improvement.

Training and Certification. Before cardholders are issued purchase cards, VHA policy requires basic training in acquisitions and reconciliation procedures, and certification to make micro-purchases (purchases under $2,500). The policy also requires the Purchase Card Coordinator (PCC) to document the cardholders' training and certification. The PCC could not provide documentation of any training or of the required certifications for 9 (9 percent) of the healthcare system's 98 cardholders. The PCC stated that all cardholders have had the basic training and were certified, but could not provide documentation to support the completion of the training.

Quarterly Reviews. VHA policy requires joint (PCC, Fiscal Activity, and Contracting Activity) quarterly reviews of cardholder accounts. Our review found that the healthcare system had not performed the joint quarterly review of cardholder accounts since November 2003, when the former voucher auditor retired and the position was eliminated.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that (a) the PCC documents all completed training and certifies all cardholders and (b) joint quarterly reviews of cardholder accounts are performed.

The VISN and System Directors agreed with the findings and recommendations. All cardholders completed training by June 2006. Training is documented in individual employee training records. Joint quarterly reviews will be completed on cardholder accounts. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

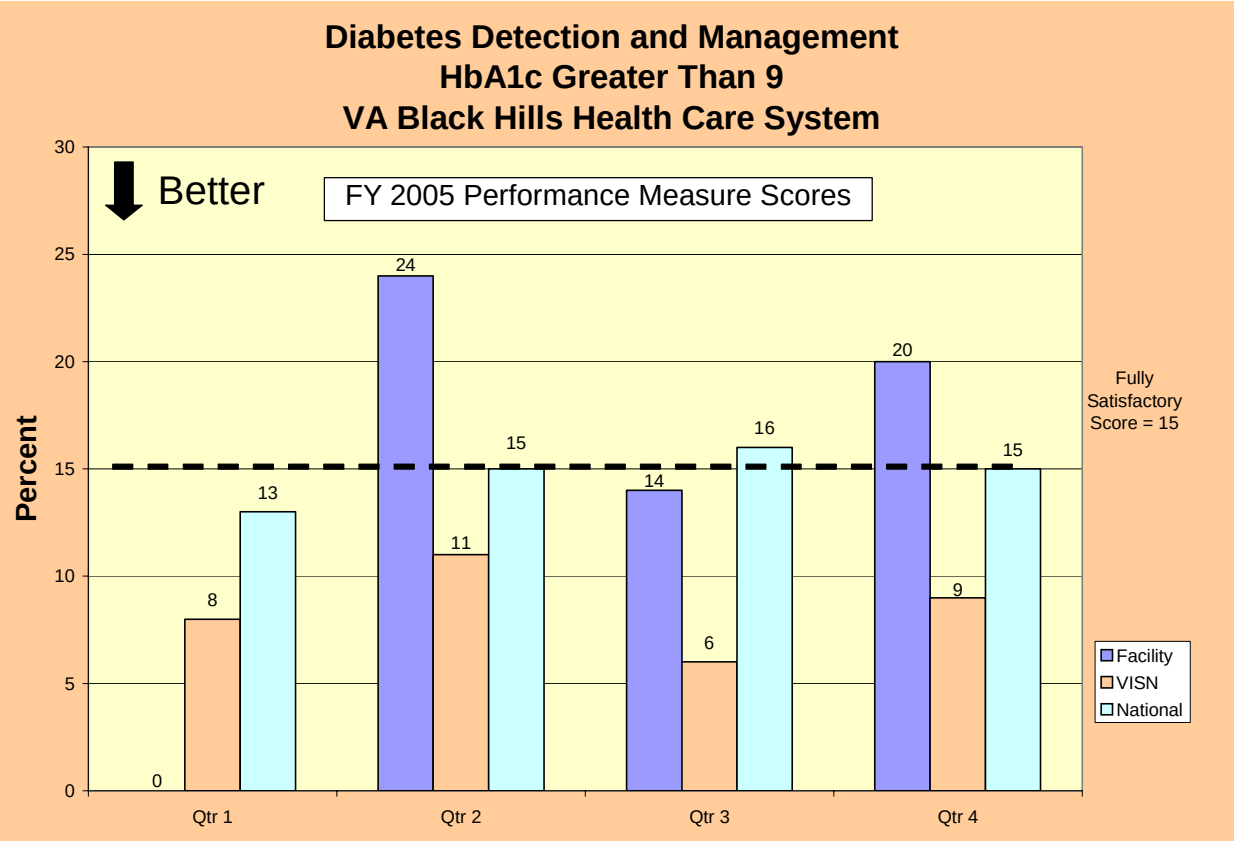
Diabetes and Atypical Antipsychotic Medications – Management of Laboratory Values and Nutritional Consultations Needed To Be Improved

Condition Needing Improvement. Clinicians needed to improve monitoring and control of diabetic patients' laboratory values and improve the management of nutritional consultation for patients who met criteria. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that: diabetic patients' hemoglobin A1c (HbA1c)[1] should be less than 9 percent; blood pressure should

[1] HbA1c reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

be 140/90 millimeters of mercury (mmHg) or less; and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl).



To receive fully satisfactory ratings for the diabetes performance measures, the medical center must achieve the following scores:

- HbA1c greater than 9 percent – 15 percent or lower
- Blood Pressure less than or equal to 140/90mmHg – 72 percent or higher
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent or higher

The system met or exceeded VHA performance measures for blood pressure monitoring and control and cholesterol control. The system did not meet the VHA performance measure for HbA1c control and had not included it on their FY 2006 performance improvement plan. The Chief of Staff verified there was no improvement plan for this measure and that it should have been included on the FY 2006 plan.

We reviewed a sample of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. Two of 13 patients had diabetes and met HbA1c and blood pressure control criteria. Although one patient had an elevated cholesterol level, clinicians had identified the problem and developed a treatment plan.

Diabetic patients with HbA1c>[2] 9 percent	Diabetic patients with B/P <140/90 mm/Hg	Diabetic patients with LDL-C< 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
0/2	2/2	1/2	10/11	10/11

The system required clinical providers to enter a consultation to dietary for a nutritional evaluation for any patient with a Body Mass Index (BMI) greater than 27 or less than 20. However, providers had not referred six of the eight patients who met these criteria. Dieticians completed timely nutritional evaluations when providers consulted them.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires clinicians to (a) implement an improvement plan to meet the performance measure for HbA1c levels and (b) provide appropriate nutritional consultations for patients meeting BMI criteria.

The VISN and System Directors agreed with the findings and recommendations. They reported that a VISN and System performance improvement (PI) team will address the HbA1c performance measure. Nutrition and Food Service employees will complete nutritional consults for patients meeting BMI criteria and will be members on the PI team. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management – Data Analysis and Reporting Processes Needed Strengthening

Condition Needing Improvement. Program managers needed to ensure that designated committees consistently analyze data in order to identify trends and make recommendations for improvement. In addition, they needed to evaluate the effectiveness of implemented improvement initiatives. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to transform data into information in order to make recommendations to improve care. The QM program generally provided appropriate oversight of clinical care; however, committees needed to clearly define follow-up actions and determine effectiveness of those actions. We interviewed employees and reviewed policies, plans, committee minutes, and reports for FY 2005.

The Clinical Executive Board (CEB) was the designated committee for QM operations and the Executive Council of the Governing Body (ECGB) served as the oversight committee. Although data was presented to these committees, it was not consistently trended and analyzed. When QM reviews identified opportunities for improvement,

[2] The symbol < means "less than"; > means "greater than."

these committees did not consistently identify action items and assign responsibility and time frames for completion and reevaluation. ECGB minutes noted actions as closed when, according to discussions, the committee should have assigned follow-up action or continued monitoring. Examples of topics that needed further action or reevaluation were VHA performance measures, medical records review, and radiology peer review. The medical staff peer review committee did not start meeting until 6 months after the VHA mandated start date and had not met every quarter, as required.

Recommendation 6. We recommended that the VISN Director ensure that the System Director takes action to implement processes that: (a) trend and analyze all data, (b) identify appropriate corrective actions with assigned time frames and responsibility, and (c) meet VHA requirements for peer review.

The VISN and System Directors agreed with the findings and recommendations. The System has hired an Organizational Improvement Coordinator who will be responsible for trend analysis and oversight of recommended corrective actions. The Peer Review Committee will meet on a quarterly basis. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Other Observations

All Employee Survey

The system 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.

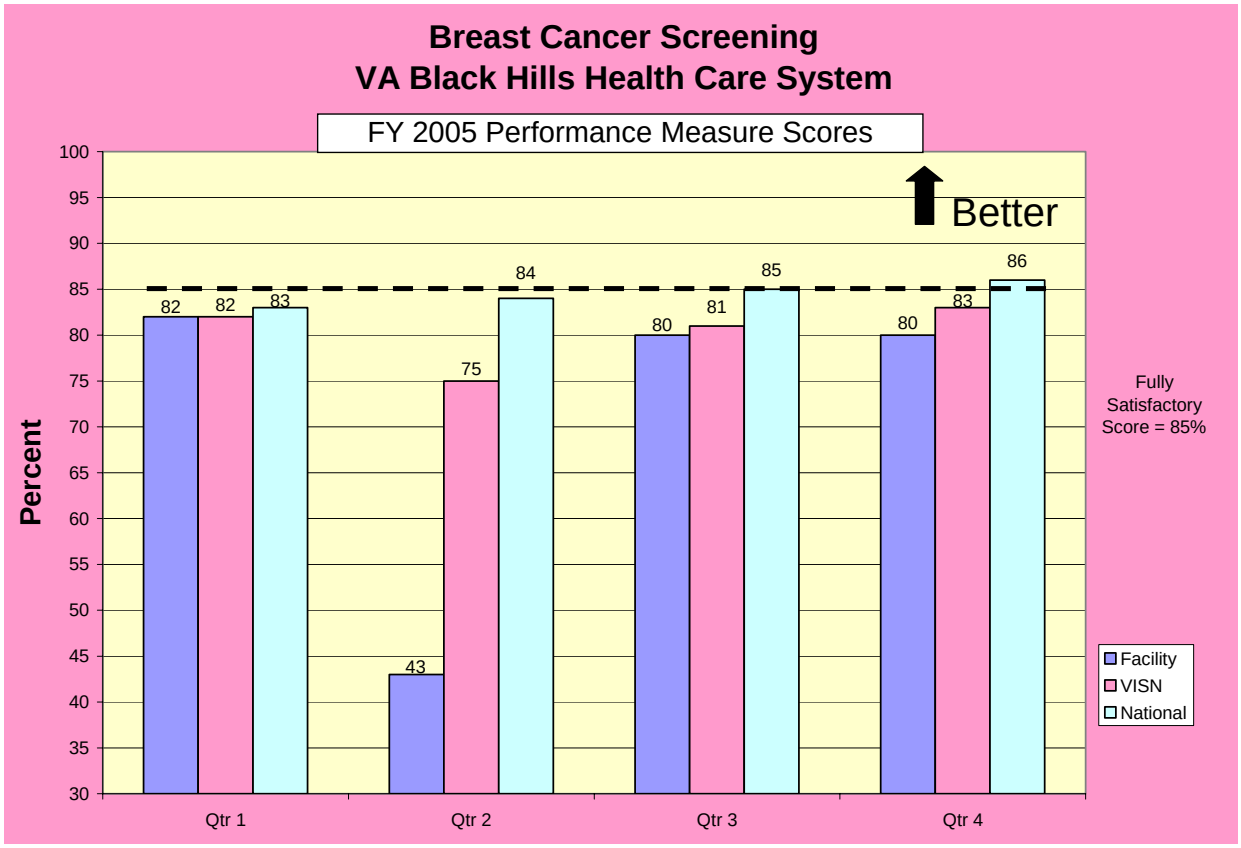
Results of the 2004 AES revealed 7 of 34 areas that were significantly above the national average. No areas were significantly below the national average. Even though system scores were above average, managers developed teams to address all areas of the survey. The teams analyzed facility department scores to determine which areas needed improvement and which were above average scores of employee satisfaction. Departments with above average scores were benchmarks for other departments. The system designed training initiatives for employees in specific areas that could show improvement.

Breast Cancer Management

The system provided timely radiology, surgery, and oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed and coordinated interdisciplinary treatment plans. Contract facilities perform mammography offsite and the system receives timely reports from those facilities.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items for the four patients who were diagnosed with breast cancer or had suspicious or highly suggestive mammogram results during FYs 2004 and 2005. Although providers had appropriately screened all the patients we reviewed, the system did not achieve the fully satisfactory score for breast cancer screening in FY 2005. Because the system had implemented performance improvement plans that included the formation of a team to identify areas contributing to the less than fully satisfactory scores, we did not make any recommendations.

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
4/4	4/4	4/4	4/4	4/4



Appendix A

Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 6, 2006

From: Director, Veterans Integrated Service Network 23 (10N23)

Subject: **VA Black Hills Health Care System**

To: Office of the Inspector General

1. Attached is VA Black Hills' response to the Office of Inspector General (OIG) Combined Assessment Program Review Site Visit conducted April 17-21, 2006. I have reviewed the CAP recommendations, which have been individually addressed.

2. I concur with the comments and actions taken by the Medical Center Director to improve processes at the VA Black Hills Health Care System.

(original signed by:)

ROBERT A. PETZEL, M.D.
Network Director

Appendix B

Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 1, 2006

From: Director, VA Black Hills Health Care System (568/00)

Subject: **VA Black Hills Health Care System**

To: Network Director, VISN 23 (10N23)

1. Attached please find our response to the Combined Assessment Program review of VA Black Hills Health Care System conducted April 17-21, 2006.

2. If you require any further information or clarification, please contact me or Steve DiStasio, Associate Director for Operations at (605) 720-7170.

(original signed by:)

PETER P. HENRY, CHE
Director

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 System Director requires that: (a) the Business Office Manager ensures all potentially billable fee-basis encounters are billed, (b) the Business Office Manager provides training on the correct use of RNB codes, (c) the MCCF staff reviews the RNB report for the period October 2004–December 2005 to identify any potentially billable encounters which were miscoded, (d) clinicians adequately document care provided to patients, and (e) the MCCF staff follow up with clinicians as needed to ensure sufficient documentation is obtained.

Concur **Target Completion Date:** January 1, 2007

a. A standard operating procedure will define the process for insufficient documentation of billable visits. The Business Office Manager will ensure the SOP is followed.

b. A check list of procedures listing the process to follow when insufficient and/or no documentation is found in the medical record was developed. A final check off will be to cancel PCE data if documentation is absent or to revise PCE data to reflect documentation available.

c. The Business Office Manager trained the business office staff on RNB codes on 5/16/06. A resource was developed with categories for use by the office staff for consistency in applying RNB in CCM.

d. The Compliance Officer and Business Office Manager will receive and review the RNB report monthly. Business Office staff will be identified for accountability and responsibility for the RNB process. The Coder Educator interacts with the Medical Staff on a daily basis completing education on documentation and coding requirements.

e. An audit of RNB records from October 1, 2005 through the Combined Assessment Program dates was completed to identify trends in documentation. A current audit is in progress of records subsequent to the assessment. The HIMS Manager and Business Office Manager will provide results to the Executive team. A method of communication with various providers was developed and implemented. The position of Coder Educator has been implemented and communication with physicians is occurring consistently. An orange query form was developed and implemented. With assistance and input from the Chief of Staff and Compliance Officer, a formal process of communication and feedback to physicians is planned.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires supply management staff to ensure the accuracy of GIP medical supply inventory records.

Concur **Target Completion Date:** January 1, 2007

a. VA Black Hills Logistics staff is directly responsible for and manage 4 of the 24 reportable GIP Inventories. Logistics staff continues to provide training, reviews, inventory spot checks and guidance to the other 20 Responsible GIP Managers and their users. Logistics staff is conducting reviews of the 20 other departments inventories in the six main GIP categories specified in the VISN/VACO requirements: Med/Surgical, Imaging, Laboratory, Dental, EMS and Engineering.

The reviews consist of the following:

a. Monthly Stock Status Reports

b. Monthly GIP Report Card

c. Inactive items >90 days supply (set by VISN)

d. Long Supply items >90 days supply (set by VISN)

e. Turn Ratio of a minimum of 8 (set locally)

f. Days of Stock on Hand Report

g. Due-In Item Report

h. Usage Items Demand Report

i. Physical Inventory Spot Checks

In performing these reviews, Logistics staff meets with the Responsible Departments and instruct them in proper procedures of utilizing and maintaining their GIP Inventories as established by VACO and VISN requirements, and provide assistance whenever possible.

Logistics provides the GIP Department Managers, users, and Executive Team with a monthly GIP Report Card and Monthly Stock status Report for their review, showing improvements made during the month and areas needing improvement.

A. Performance Improvement team on GIP Inventory comparison analysis was conducted from July 05 to July 06 with the following results:

a. Reduction in overall GIP Inventory by $108,016.74

b. Reduction in overall Inactive items by 175

c. Reduction in overall Inactive dollars by: $43,648.62

d. Reduction in overall Long Supply items by 415

e. Reduction in overall Long Supply dollars by $92,270.94

Two mandatory GIP Refresher training sessions have been conducted with GIP Inventory Users and Managers.

Logistics staff will continue to monitor and make recommendations on all GIP Inventories.

B. The VA-BHHCS Executive Team is reviewing the addition of GIP performance to appropriate Service Chiefs Performance Measures.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires the Logistics Service Chief to (a) ensure responsible staff complete required EIL inventories within established time frames and (b) conduct quarterly spot checks of EILs to verify inventory accuracy.

Concur **Target Completion Date:** January 1, 2007

EIL Inventories:

a. Ensure responsible staff complete required EIL inventories within established time frames.

1. Procedures are in place for VA Black Hills Logistics staff to send out EIL and Non-EIL inventories to Department Officials a minimum of 10 and 20 days prior to inventory due dates, depending on the size of the inventory. On each EIL and Non-EIL is a document showing the due date and routing system for return of the completed EIL and Non-EILs, included are the procedures for requesting, through the Director's Office, an extension of time for completion if needed. The Department Official must request an extension from the Director for more time to complete the delinquent EIL and Non-EIL.

2. Upon receipt of the completed EIL and Non-EIL inventories, Logistics staff will update each item in AEMS/MERS with the completion date.

3. Logistics staff send out delinquent notices to the Department Official that have not returned their respective EILs and Non-EILs by the established due dates, with a copy routed to the Director.

Quarterly Spot Checks:

1. In accordance with VA Handbook 7127-5302.3(e), Facilities Management Service staff have been conducting quarterly spot checks of EIL inventories since October 1 2005, and have those spot checks on file.

2. Logistics Service has established that Quarterly spot checks will be conducted after the Responsible Official returns the EIL inventory on or before the respective due date, so proper verification of items and locations can be obtained.

3. Quarterly spot checks for 3rd and 4th quarter FY 06 were not conducted since those EILs were not scheduled for their annual inventory yet. Logistics will perform a spot check when those inventories become due.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that (a) the PCC documents all completed training and certifies all cardholders and (b) joint quarterly reviews of cardholder accounts are performed.

Concur **Target Completion Date:** January 1, 2007

a. All cardholders completed refresher Purchase Card training by June 2006. The training is documented in each individual's training record. A computerized Purchase Card mandatory annual refresher training course is being developed. The target completion date for the computerized training development is 1/1/07.

b. Joint quarterly reviews will be completed on cardholder accounts. A list of current purchase card holders is accessible and identified individuals are responsible for completing these audits.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires clinicians to (a) implement an improvement plan to meet the performance measure for HbA1c levels and (b) provide appropriate nutritional consultations for patients meeting BMI criteria.

Concur **Target Completion Date:** January 1, 2007

a. A VISN Service Line team is addressing this performance measure at a network level. A performance improvement team is being developed to address this performance measure at the local level. The action taken at the local level will include the Primary Care Service Line as well as the MH Service Line.

b. Nutrition and Food Service will complete consultations for patients meeting BMI criteria through a consult process. NFS will be active members on the performance improvement team.

Recommendation 6. We recommended that the VISN Director ensure that the System Director takes action to implement processes that: (a) trend and analyze all data, (b) identify appropriate corrective actions with assigned time frames and responsibility, and (c) meet VHA requirements for peer review.

Concur **Target Completion Date:** October 1, 2006

a. The Organizational Improvement Department will trend and analyze all data acquired on performance measures in addition to the responsible service line leaders. Trends and analyses will continue to be reported to the Clinical Executive Board and the Executive Leadership of the VA-BHHCS. Included in the trends and analyses will be recommendations for actions to improve identified deficiencies. Is has also been made a key performance expectation of our newly-hired OI Coordinator.

b. The Clinical Executive Board and Executive Leadership will recommend additional actions and identify required time frames and responsible individuals. The Organizational Improvement Department will provide oversight of the performance measures and assist responsible service line leaders through education, assistance with trending and analyzing and with process improvement development and implementation.

c. The Peer Review Committee will meet on a quarterly basis per VHA requirements for peer review.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Improve MCCF billing procedures and clinical documentation	$22,501
	Total	$22,501

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia Solana, Regional Director Kansas City Office of Healthcare Inspections 816/426-2016
Acknowledgments	Dorothy Duncan – CAP Team Leader Andrew Hamilton Tamara Jacobson Jennifer Kubiak Andrea Lui Shoichi Nakamura Kim Rosetta James Seitz Marilyn Stones Jeff B. Wieters

Appendix E

Report Distribution

VA Distribution

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Director, VA Black Hills Health Care System (568/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kent Conrad, Byron L. Dorgan, Michael B. Enzi, Charles T. Hagel, Timothy P. Johnson, E. Benjamin Nelson, Craig Thomas, John Thune
U.S. House of Representatives: Barbara Cubin, Stephanie Herseth, Tom Osborne, Earl Pomeroy

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