Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review
VA Medical Center
Miami, Florida

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VA Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort to ensure that high quality health care is 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 on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare inspectors evaluate how well the facility is meeting quality standards in specific core areas and the level of patient satisfaction with overall treatment.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

Combined Assessment Program Review
VA Medical Center Miami, Florida

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program review of VA Medical Center (VAMC) Miami, Florida, during the week of November 13-17, 2000. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care and quality management, financial and administrative management controls, and fraud prevention.

The 448-bed medical center offers primary, secondary, and tertiary diagnostic and therapeutic health services in medicine, surgery, neurology, rehabilitation medicine, intermediate care, spinal cord injury, skilled nursing home care, and palliative care, as well as primary and secondary levels of psychiatric care. Fiscal Year (FY) 2000 expenditures were approximately $213.5 million and the staffing level was about 2,100 full-time equivalent employees. In FY 2000 the VAMC treated about 5,925 inpatients and provided about 413,000 outpatient visits.

Patient Care and Quality Management. VAMC managers' attitudes and actions supported quality management and performance improvement. The VAMC administered a comprehensive, well organized, quality management program that effectively coordinated patient care activities and properly monitored the quality of care. However, some issues related to patient care oversight needed senior managers' attention.

We suggested that the Director address patient care oversight issues as follows: (a) make improvements to root cause analyses, Boards of Investigation, and patient incident reporting; (b) improve outpatient documentation and coding; (c) ensure timely access to the Pain Clinic; (d) fully implement Veterans Health Administration's "*Pain as the 5th Vital Sign*" initiative; (e) improve clinical and administrative aspects of the community nursing home program; and (f) improve the Bar Code Medication Administration system.

Financial and Administrative Management. Financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we suggested that the VAMC Director: (a) conduct monthly unannounced inspections of controlled substances; (b) refer appropriate accounts receivable to the Regional Counsel; (c) implement corrective actions identified by Veterans Integrated Service Network 8 on unliquidated obligations; (d) strengthen controls over time and attendance for part-time physicians; (e) strengthen internal control procedures over purchase cards; (f) schedule unannounced audits of the agent cashier more frequently; (g) enhance automated information system security;

(h) reduce billing lag times for Medical Care Collection Fund recoveries; and (i) aggressively promote the Employee Suggestion Program. We also recommended that the VAMC Director improve control over inventory management, and ensure that preventive maintenance on refrigeration and air conditioning equipment is performed as required.

Fraud Prevention. Top management supported fraud prevention efforts but some managers did not report allegations of fraud to the OIG as required. We suggested that the Director monitor this condition. During the review we provided fraud and integrity awareness training for 311 employees. The training included instructions to managers on the requirements for reporting allegations of fraud.

Medical Center Director Comments. You concurred with the findings and recommendations in the report and provided acceptable implementation plans. Therefore, we consider the issues to be resolved. However, we will continue to follow up on those planned actions that are not completed.

(Original signed by)

RICHARD J. GRIFFIN
Inspector General

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Introduction

VA Medical Center Miami

VA Medical Center (VAMC) Miami provides primary, secondary, and tertiary diagnostic and therapeutic health services in medicine, surgery, neurology, rehabilitation medicine, intermediate care, spinal cord injury, skilled nursing home care, and palliative care, as well as primary and secondary levels of psychiatric care. The VAMC operates two satellite outpatient clinics located in Key West and Oakland Park, and three community-based outpatient clinics in Pembroke Pines, Key Largo, and Homestead. The facility is part of Veterans Integrated Service Network (VISN) 8, the VA Sunshine Healthcare Network, which includes VAMCs and outpatient clinics in Florida, Puerto Rico, and the Virgin Islands.

Affiliations and Programs. The VAMC is affiliated with the University of Miami School of Medicine and 30 other colleges and universities in Allied Health Science Programs such as nursing, social work, pharmacy, dietetics, rehabilitation, computer sciences, dental, clinical pastoral education, health administration, podiatry, and speech pathology. The facility offers a broad range of diagnostic and therapeutic programs including a spinal cord injury center, supervoltage therapy, a hemodialysis center, open-heart surgery, and a prosthetics treatment center.

Resources. Fiscal Year (FY) 2000 expenditures were approximately $213.5 million. Staffing totaled about 2,100 full-time equivalent employees. The VAMC had 166 medical, 48 surgical, 90 psychiatric, and 144 nursing home beds available at the beginning of FY 2001.

Workload. In FY 2000, the VAMC provided about 67,000 inpatient days of care to about 5,925 medical, surgical, and psychiatric patients and about 51,400 inpatient days of care to 276 nursing home patients. The average daily census was 104 medical, 27 surgical, 52 psychiatric, and 141 nursing home inpatients. The outpatient workload was about 413,000 visits.

Objectives and Scope of Combined Assessment Program

The purposes of the Combined Assessment Program (CAP) review were to evaluate selected clinical, financial, and administrative operations, and to provide fraud and integrity awareness training to VAMC employees.

Patient Care and Quality Management Review. We reviewed selected clinical activities with the objective of evaluating the effectiveness and appropriateness of patient care and quality management (QM). The QM program is comprised of a set of integrated processes that are designed to monitor and improve the quality and safety of

patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and ensuring employee competence.

To evaluate the QM program and patient care management, we inspected patient treatment locations, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. We used questionnaires and interviews to evaluate patient satisfaction and solicited their opinions and perceptions about the quality of care. We reviewed the following functions:

- Pain Clinic
- QM Program
- Community Nursing Home Program
- Narcotics Use in Mental Health
- Root Cause Analyses
- Patient Incidents
- Nurse Staffing
- Pain Management in Acute Care
- Physician Credentialing and Privileging
- Outpatient Documentation and Coding
- Boards of Investigation
- Bar Code Medication Administration

Financial and Administrative Management Review. We reviewed selected financial and administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed managers and employees, and reviewed pertinent financial, administrative, and clinical records. The review covered the following financial and administrative activities and controls:

- Agent Cashier Operations
- Pharmacy Service Security
- Enhanced Use Lease Agreements
- Community Nursing Home Contracts
- Automated Information System Security
- Medical Care Collection Fund
- Employee Suggestion Program
- Inventory Management
- Telephone Security
- Purchase Card Program
- Accounts Receivable
- Unliquidated Obligations
- Preventive Maintenance
- Timekeeping for Part-time Physicians

Fraud Prevention. We conducted four fraud and integrity awareness briefings for 311 VAMC employees. The presentations included a brief film on the types of fraud that can occur in VA programs, a discussion of the Office of Inspector General's (OIG's) role in investigating criminal activity, and a question and answer session.

Scope of Review. The CAP review generally covered VAMC operations for FY 2000 and October 2000. The review was done in accordance with Standard Operating Procedures for the VA Office of Inspector General Combined Assessment Program.

Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

We concluded that the patient care and QM programs were comprehensive and generally well managed, and that clinical activities were operating effectively, as illustrated by the following examples:

The QM Program Was Comprehensive and Well Organized. The VAMC's QM program included utilization review, performance improvement, risk management, and administrative investigations. We inspected incident reports, administrative investigations, root cause analyses/focused reviews, tracking of external review recommendations, peer reviews, and tort claims. We found that QM employees were proactive, conducting 100-percent utilization reviews and identifying and targeting high volume, high cost, and high vulnerability issues for review. The Quality Leadership Council actively oversees the work of improvement teams, clinical subcommittees, and other QM activities. Overall, we concluded that the QM program was a well-established component of medical center operations.

Most Patients Were Satisfied With the Quality of Care. We interviewed and surveyed 35 patients about the quality of care provided by the VAMC. The results of our interviews and surveys showed that over 92 percent of the patients rated the quality of care provided as good, very good, or excellent. Additionally, almost 86 percent would recommend care at the VAMC to family members or friends.

The Credentialing and Privileging Process Was Well Organized. Veterans Health Administration (VHA) policy and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards define the credentialing, privileging, reappraisal, and reprivileging process for healthcare practitioners in VA settings. We examined the VAMC's credentialing and privileging policies and procedures to determine if credentials of physicians treating VA patients were properly evaluated and approved. We found that information gathered from the peer review process was forwarded to the respective service chief for inclusion in the physician proficiency and reprivileging process. The evaluation of nine credentialing and privileging files verified compliance with VHA and JCAHO regulations.

Psychiatrists Properly Controlled Narcotic Prescriptions Given to Mental Health Patients. JCAHO standards require that healthcare organizations have controls in place to ensure that the rationale for prescribing long-term (maintenance) narcotics is adequately documented in the medical records. Because the mental health population is often at considerable risk for addiction or other undesirable side effects, we analyzed the prescription-writing practices of attending psychiatrists. The six psychiatrists that we

interviewed reported that they did not routinely prescribe narcotics, but referred any patient requiring long-term pain management to a primary care provider or the Pain Clinic. Our medical record review and database search confirmed this practice.

Opportunities for Improvement in Various Patient Care, QM, and Administrative Functions

Some patient care, QM, and administrative issues required senior managers' attention. We made suggestions for improvements in the following areas:

Managers Should Make Improvements to Root Cause Analyses, Boards of Investigation, and Patient Incident Reporting. We reviewed 12 months of root cause analyses, Boards of Investigations, and the tracking and trending of patient incidents. Our findings on these programs were as follows:

Root Cause Analyses - The VAMC had an effective mechanism in place for conducting root cause analyses and followed the Veterans Health Care Patient Safety Handbook. Evidence existed that the medical center documented findings of root cause analyses and identified opportunities for improvement. However, the analyses needed to include evidence of follow-up on recommendations. Senior managers need to require status reports of follow-up actions from the responsible line managers.

Boards of Investigation - Boards of Investigation were limited in scope, and their quality was inconsistent and often inadequate to provide useful or meaningful information to identify causative or contributory factors. We also found that members of the boards often asked leading questions of witnesses. Managers acknowledged that employees were reluctant to testify against their co-workers, thus hindering the Board of Investigation process. Investigators should be trained to effectively conduct Boards of Investigation.

Patient Incident Reporting - Overall, reports of Special Incidents Involving a Beneficiary, were thoroughly addressed with appropriate corrective actions taken. Nonetheless, we identified four incidents that staff did not report. VAMC managers agreed that staff should have reported these incidents. Managers need to address with all employees the importance of reporting incidents.

Providers Should Improve Outpatient Documentation and Coding. VHA has increased its efforts to comply with Medicare billing regulations and JCAHO standards for appropriate documentation. Previous VHA studies have shown recurring problems with improper billing and inadequate supporting documentation VA-wide. We reviewed 39 medical records to determine clinicians' compliance with coding and billing standards. We selected medical records based on predefined outpatient encounter codes (Evaluation and Management codes 99201 - 99205 and 99211 - 99215). The selected codes encompassed routine to complex care. We used reporting criteria outlined in Health Care Financing Administration (HFCA) guidelines.

We found that documentation did not support the assigned encounter codes in 34 of 39 (87 percent) medical records. Of the 34 encounters that were incorrectly coded:

- 19 (49 percent) were up-coded (reflecting a higher complexity of service than actually occurred);

- 12 (31 percent) were down-coded (reflecting a lesser complexity of service than actually occurred); and

- 3 (8 percent) were incorrect (the designations of "new patient" and "established patient" were interchanged).

Also, the VAMC did not have a compliance officer or compliance policy. A compliance officer is generally assigned to this process to monitor such issues as billing for resident services, and can provide expert advice to staff and management on ways of improving the billing process. The VAMC was in the process of recruiting a compliance officer at the time of our review. The compliance officer will have responsibility for the development of local compliance policy.

We confirmed that providers were given instructions on coding and documentation standards, and 12 of the 14 employees surveyed agreed that training had been provided. However, our review did not indicate provider understanding of proper coding. Managers should enhance training in order to improve provider compliance with coding and documentation standards.

Managers Should Address Pain Clinic Waiting Times. The next available appointment in the Pain Clinic was not until August 2001, and there were more than 375 consult requests pending action. This clinic has a full-time physician and a full-time nurse. The clinic physician-manager advised that the primary care physician manages most chronic pain patients until seen by the Pain Clinic team, and emergency cases are worked into the schedule to ensure prompt evaluation and treatment. Medical center managers were aware of the delays in the Pain Clinic and although they indicated they would like to hire another physician, they felt restricted by requirements to staff specialty programs first. Medical center managers should consider the following actions to reduce delays in scheduling Pain Clinic appointments:

- Assess the feasibility of realigning physician resources to support high volume treatment locations like the Pain Clinic.

- Determine the appropriateness of using fee basis services to decrease the waiting list.

- Revise the medical center policy to allow designated primary care physicians to write opiate prescriptions for their long-term chronic pain patients.

Implementing VHA's *Pain as the 5th Vital Sign* Initiative Could Be Improved. VHA launched its *Pain as the 5th Vital Sign* (Pain) initiative in 1998 in response to national studies, which suggested that pain was not routinely assessed and treated in hospital and clinic settings. We conducted medical record reviews on patients with selected diagnoses who may have experienced pain during their hospital stays. We examined the educational records of randomly selected caregivers and we evaluated the VAMC's draft policy on pain management. The purpose of this review was to assess bedside compliance with the Pain Initiative and determine whether assessments, treatments, and documentation in medical records were appropriate.

We reviewed 10 patients' medical records with the following positive findings:

- Nine records contained initial pain assessments.

- The medical records of the six patients identified as having pain on admission included documentation of the pain score, location, intensity, character, and prior response to treatment components.

- The nursing care plan and the patient response to pain management were documented in each of eight applicable cases.

Some improvement was needed in the following areas:

- The duration of pain component was missing from both the Intensive Care Unit nursing template and the medical/surgical nursing assessment form in all 10 records. This could account for the absence of duration of pain information in the applicable medical records.

- The pain scores were recorded with vital signs in only four cases.

- None of the medical records reflected patient or family education regarding pain management.

- Although six of seven applicable medical records contained documentation of discharge planning on pain, in each case it was a cursory note on the Discharge Instructions form.

We studied the education records of 12 employees including physicians, nurses, and a physician's assistant to determine if they had received pain management training since 1998. Only 2 of 12 (17 percent) of the education records reflected pain management training. Pain Clinic employees had recently conducted educational programs during Pain Awareness Week and planned additional training for primary care groups in December 2000.

The VAMC's Pain Management policy could be improved by:

- Expanding the policy to include all medical center clinical areas - including outpatient clinics and community-based outpatient clinics.

- Including discharge planning guidelines, QM review guidelines, and employee educational requirements.

VAMC managers should ensure that the revised pain management policy addresses the items listed above, and that clinicians properly adhere to the published policy. Managers should refer to VHA's *Pain as the 5th Vital Sign* publication for additional guidance.

Managers Should Improve Clinical and Administrative Aspects of the Community Nursing Home (CNH) Program. We evaluated the CNH program to determine if: (a) contract reimbursement rates were within VHA guidelines; (b) required management and clinical oversight functions existed; and (c) local CNH policy complied with VHA guidelines. We interviewed program staff and examined contract files, patient records, and local policy. We also visited one of the contract nursing homes where we interviewed the administrator as well as two veterans receiving care.

At the time of our review, there were 20 patients placed in 10 CNHs. A social worker was coordinator of the program. There were two additional social workers and five nurses assigned to patient visitation in the CNHs. None of these employees were dedicated solely to the CNH program. Program managers were in the process of recruiting a full-time clerk to serve as program coordinator, handle most of the administrative tasks related to the contracts, and coordinate the CNH veterans' outpatient clinic appointments at the VAMC.

Contract Rates - Contract reimbursement rates were within VHA guidelines as required.

Oversight Functions - We found that, despite VHA guidelines that require monthly visitation to all veterans in contract nursing homes by a nurse or social worker, monthly visitations were not occurring on a consistent basis. Of seven applicable medical records, only one had documentation of a visit by VA clinicians each month after the veteran's admission to the CNH. VHA policy also requires that a VA nurse visit these patients at least once every 60 days (usually, this is alternated with the social worker's visits). We did not find documentation that this visit was occurring consistently in any of the six applicable medical records reviewed. We also did not find documentation of an annual physical examination and the need for continued nursing home placement in either of the two applicable (indefinite contract patients) medical records.

VHA guidelines require that all CNHs receive, at a minimum, an annual inspection conducted by a VA nurse and social worker. VAMC managers approved an alternative

method for overseeing the CNHs. Inspection team members examine HCFA reports of CNH deficiencies and, if satisfactory, forgo an on-site inspection. An inspection form was completed by the nurse and social worker annually, and submitted to the team for review, but the form was completed without the benefit of an actual on-site inspection. Additionally, the completion of the form sometimes predated the team review of the HCFA report by several months.

We also found that there was no formal designation of a Contracting Officer's Technical Representative (COTR) for this program as required. The CNH Coordinator had been functioning in this role in an informal capacity, but had not signed a formal delegation of authority. Program managers took immediate action to resolve this issue and had a COTR formally designated for each contract during our visit. Our review of contract files showed that this program also did not receive medical staff concurrence of their contracts.

The contracts with the CNHs require the homes to provide the VAMC with Minimum Data Set information on each patient upon admission and every 6 months thereafter. The VAMC did not obtain this or any other performance improvement data (such as patient satisfaction survey results or incidence of falls) as required by VHA policy.

Local Policy - The facility's policy did not comply with current VHA directives in several key areas. Specifically, policy did not mandate monthly visits to CNH veterans or include provisions for collection and analysis of performance improvement data. Local policy also did not designate all required members of an inspection team.

We suggested that program managers take steps to ensure compliance with mandated oversight activities such as monthly visits, annual physicals, and documentation of the need for continued nursing home placement. We also suggested that managers develop a comprehensive system for annual inspections and create templates to document oversight activities. Program managers agreed to revise local policy to be consistent with VHA requirements, have contracts approved by the medical staff, analyze performance improvement data, and share findings with the QM Coordinator quarterly.

The Bar Code Medication Administration (BCMA) System Needs Improvement. In accordance with VHA directives, the VAMC implemented BCMA in June 2000. According to employees in Pharmacy and Nursing Services, multiple equipment breakdowns made BCMA cumbersome and inefficient to use. Nurses reported difficulty using hand-held scanners on patient wristbands, problems with scanner batteries discharging in the middle of medication passes, and concerns with BCMA computers running slow or locking-up for several hours. Staff reported at least 14 hardware or software problems since July. Although we could find no evidence of adverse events related to inoperable BCMA equipment, several clinicians asserted that, due to BCMA inefficiencies, some nurses "found ways around" using the system.

A BCMA focus group was implemented to address complaints about equipment and software, and managers advised us that they had responded to concerns as they arose. Twelve additional BCMA carts were ordered to increase the number of nurses able to administer medications on a ward at the same time. Despite these efforts, staff may not be using BCMA as intended because of non-functional equipment.

A CAP review at Hunter Holmes McGuire VAMC Richmond, Virginia documented that the BCMA system was implemented with minimal problems. VAMC managers should contact that facility for information on how they resolved any problems that they experienced with implementation of BCMA. Managers also need to conduct an in-depth analysis of any factors contributing to BCMA's inefficiencies including equipment problems, employee training, and employee resistance, and develop a plan to overcome identified barriers.

Financial and Administrative Management

Management Controls Were Generally Effective

Financial and administrative activities reviewed were generally operating satisfactorily. We found no internal control weaknesses in the following two activities.

Service Contracts. Controls over a $213,600 contract for provision of valet parking services and a $185,580 contract for recycled printer product services ensured effective contract administration.

Enhanced Use Lease Agreements. Space utilization at the facility did not provide any opportunity for developing enhanced use lease agreements at the time of our review. Managers did not anticipate any significant changes in space utilization in the near future that would provide the opportunity for developing such agreements.

Opportunities for Improvement in Financial and Administrative Functions

During our review, we noted some financial and administrative issues that warranted management attention. We made suggestions for improvements in the following areas:

Pharmacy Service Should Conduct Monthly Unannounced Inspections of Controlled Substances. Physical security of pharmacy areas was adequate, inspectors received appropriate training, staff disposed of unusable drugs quarterly, and managers followed guidelines for appropriately assigning employees to inspection teams. However, a review of records of the monthly inspections of all Schedule II, III, IV, and V controlled substances for the period January through October 2000, showed that employees did not conduct 8 of the 10 required inspections. Additionally, local inspection guidelines improperly instructed inspectors to pre-schedule their inspections rather than make them unannounced. Inspections were scheduled as much as a week in advance. The VAMC needs to comply with requirements for monthly inspections of controlled substances.

Fiscal Service Should Refer Appropriate Accounts Receivable to Regional Counsel. Facility staff followed up on accounts receivable as required, based on a sample of 10 accounts receivable totaling about $1 million. However, 6 (60 percent) of these third party accounts receivable totaling almost $290,000 should have been referred to the Regional Counsel with a recommendation for suspension, write-off, enforced collection, or further guidance as outlined in VA policy after collection efforts proved unsuccessful.

Managers Should Implement Corrective Actions Identified by VISN 8 on Unliquidated Obligations. A review by VISN 8 in March 2000 identified the need to improve follow-up on unliquidated obligations at the VAMC. Managers outlined a plan to address the conditions, but our review showed that the condition had not been corrected. Top management should oversee implementation of corrective action until the deficiencies are resolved.

Managers Should Strengthen Controls Over Time and Attendance for Part-time Physicians. Most part-time physicians appeared to comply with their work schedule. However, we could not locate three surgeons for whom we attempted to verify their attendance at the VAMC on selected dates and times of their regular work schedules. Their timekeeper was the Administrative Assistant to the Chief, Surgical Service. The timekeeper assisted in our review and could not verify their attendance. Subsequently, the Chief of Staff reported that the surgeons were performing tasks associated with research at the times in question. The Director agreed that better controls were needed to ensure that the surgeons were meeting their part-time obligations and that they would develop such controls.

The Purchase Card Coordinator Should Strengthen Internal Control Procedures. The VAMC effectively managed the purchase card program. Managers ensured that regular program quality reviews and audits were conducted as required to ensure that items purchased under this decentralized procurement method were actually received, charges were for official purposes only, and bills were correctly paid. In FY 2000, cardholders processed 18,783 purchase transactions totaling almost $9.3 million. We noted two areas of the program with potential for improvement:

Approving Official Certifications - VA policy requires certification of reconciled purchase transactions within 14 days of receipt from the cardholder. Approving officials exceeded this period for 2,611 transactions (14 percent of the 18,783 total transactions) valued at almost $1.2 million. Although program managers regularly monitored this condition, they should pursue more aggressive means of reducing the percentage of late certifications.

Proper Costing - Purchase cardholders should cost their purchases to the correct fund control point, cost center, and budget object class. Recurring reviews identified a problem with staff complying with this requirement, but did not evidence sufficient corrective action to eliminate the practice by some staff.

Managers Should Schedule Unannounced Audits of the Agent Cashier More Frequently. VA policy requires an unannounced audit of the agent cashier's advance at least every 90 days. The dates and times of unannounced audits should be varied to prevent the establishment of a pattern, and to ensure the element of surprise.

We reviewed the results of the last five audits performed through mid-November 2000. Staff performed audits from 52 to 127 days after the prior audit. Three audits exceeded the 90 days interval - 92, 121, and 127 days. As of November 14, a current audit had not taken place since June 14, 2000, thereby exceeding 150 days. The facility generally met other guidelines relating to separation of duties, security over the agent cashier area, appropriateness of the agent cashier's $25,000 advance, and training for agent cashier audits.

Managers Should Enhance Automated Information System (AIS) Security. Contingency plans, local policy, and records related to complying with the wide range of security issues under the AIS program were appropriately documented. The VAMC generally met guidelines for protecting AIS resources from unauthorized access, disclosure, modification, destruction, and misuse. Program managers agreed that they could further enhance some aspects of the AIS security function in the following areas:

Disgruntled Employees - Security policy did not address procedures for handling disgruntled employees or employees in a reduction-in-force situation. Managers agreed to formalize their local practice by including their procedures in their security policy.

Personal Computers - Staff did not monitor virus control and copyright infringement on a recurring basis for stand-alone personal computers. Staff had intermittently monitored controls over personal computers in these security areas. They agreed that an on-going, documented program of audits could be accomplished appropriate to the level of risk involved.

Certifications - Staff were not documenting certifications that discarded or transferred storage media was cleared of sensitive information.

Shorter Billing Lag Times Could Increase Medical Care Collection Fund (MCCF) Recoveries. The facility MCCF program collected over $4.5 million in FY 2000. However, program officials stated that the average time to prepare a bill following receipt of care was about 75 days for FY 2000. Although VA policy does not contain a standard for the number of allowable days to prepare the bill after receipt of care, many private hospitals and contract services average 9 days to issue bills to insurance carriers. Also, studies have shown that shorter lag times improve recovery rates. Aggressively pursuing causes for the average billing time to exceed 10 days could increase collections.

Managers Should Aggressively Promote the Employee Suggestion Program. Employee suggestions offer significant potential for identifying ways of improving facility operations and services. However, the program at the VAMC has not been active recently. Only four employees submitted suggestions in FY 2000. Staff overseeing the Employee Suggestion Program stated that promotion of the program for at least 2 years

was generally limited to mentioning the program in employee orientation. We noted that:

- The local "Incentive Awards" policy written in 1984 included two paragraphs on "Suggestions" that did not provide sufficient program information.

- A recently developed "Employee Suggestion Booklet" available in Human Resources Management Service provided appropriate program information, but the service had not widely disseminated the booklet.

- The program was not promoted on bulletin boards, by e-mail distribution, with an Employee Suggestion Week, or by similar means of facility-wide communication.

- No goals for assessing the success of the program were outlined and monitored.

Addressing such means of strengthening the Employee Suggestion Program could result in ideas for increasing outreach to more veterans and for identifying facility program improvements and cost savings.

Recommendations for Improving Management Controls

Managers Should Improve Control Over Inventory Management. Employees used the Generic Inventory Package (GIP), an automated supply inventory system, to manage the stock in two major inventory program areas: supply, processing, and distribution (SPD); and warehouse stock. These two areas contained 973 line items of stock valued at about $957,000.

Staff generally maintained accurate records of inventory in the warehouse stock; however, there was a 30-percent error rate in the November 14 inventory records for SPD, based on our sample of 10 line items. SPD records showed stock on hand for our sample of 10 line items consisting of 8,349 units of issue valued at about $9,560. Actual stock on hand was 5,825 units of issue (70 percent of 8,349) valued at about $6,210.

We could not determine if the $324,800 of inventory in excess of a 30-day supply in SPD, based on GIP records, was a reasonable reflection of stock on hand because of the significant error rate in SPD records we tested. Managers should update SPD records and determine if any overstock exists and follow-up accordingly.

Warehouse records did evidence excess stock. Generally, inventories should not exceed a 30-day supply, and even lower supply levels for additional economies can be achieved using present day electronic commerce initiatives. Of 231 lines items valued at about $440,250, 48 line items exceeded the 30-day supply by approximately $103,000.

Recommendation 1 - The VAMC Director should reduce inventories to 30-day levels.

Medical Center Director Comments

The Director concurred with the finding and recommendation. A wall-to-wall inventory of SPD inventory items was conducted and inventory records were updated to reflect the actual levels on hand. GIP will be implemented for all other managed inventory. Until full implementation is completed, the SPD staff will correct inventory discrepancies at the time errors are noted to allow for consistency of inventory data.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the report recommendation and we consider these issues resolved.

Managers Should Ensure That Preventive Maintenance on Refrigeration and Air Conditioning Equipment Is Performed as Required. Regularly conducted maintenance contributes to the longevity of equipment and enhances environmental safety. Staff at the facility expressed concern over the lack of preventive maintenance on such equipment as drinking fountains, ice machines, and induction fans. Staff noted that filters in some drinking fountains and ice machines, and "squirrel cages" in induction fans, needed regular cleaning to prevent development of unsafe bacterial growth. We examined three drinking fountains, two ice machines, and six induction fans, and found what appeared to be questionable discoloration and bacterial growth within or on them. We confirmed that scheduled maintenance had not been performed on a regular basis for at least 2 years. At our request, the infection control staff took cultures of the unsanitary conditions that we noted for reporting to the Director, and should follow-up as necessary.

According to staff in the Air Conditioning Unit, their managers had directed them several years ago to discontinue regular maintenance, but within the last couple of months had directed that staff catch up on the maintenance by addressing it full-time. Managers said they did not direct staff to discontinue regular maintenance, but confirmed that they recently directed staff to concentrate all of their time on catching up on incomplete preventive maintenance. Preventive maintenance records showed that managers were aware that such maintenance was not performed for a long period of time and seemingly had not addressed the condition until recently.

Top management should assess the performance of preventive maintenance in all program areas to ensure that the condition is not more widespread, and follow up accordingly. Staffing reductions in the Air Conditioning Unit may have contributed to this condition, and should be addressed.

Recommendation 2 - The VAMC Director should ensure that preventive maintenance is performed as required.

Medical Center Director Comments

The in-house preventive maintenance program and National Primary Drinking Water Regulations were reviewed and revised to increase preventative maintenance to appropriate levels. For the next 12 months, Facilities Management will report monthly to the Infection Control Committee that the preventative maintenance has been performed.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the report recommendation and we consider these issues resolved.

Fraud and Integrity Awareness

While on site, we conducted a preliminary review of medical records pertinent to an ongoing investigation regarding the alleged diversion of government pharmaceuticals from the medical center. As a result of the review, several new leads were uncovered.

Managers Should Ensure That All Alleged Fraud Is Reported to the OIG as Required by Policy. We learned that some managers at the medical center were apparently not reporting allegations of fraud to the OIG as required by MP-1, Part 1. Instead of a referral to the OIG, the medical center was initiating and conducting its own administrative inquiries into alleged criminal/fraud matters. As a result, some employees reported having lost trust in the system, and were of the opinion that upper management was involved in a conspiracy to cover up fraud, waste, abuse, and mismanagement. As part of our site visit, we provided training to employees regarding requirements for referral of fraud cases to the OIG. Management should ensure that all staff understand these requirements and that management reports allegations of fraud to the OIG as required.

Fraud and Integrity Awareness Briefings

As part of the CAP review, an Office of Investigations agent conducted four 90-minute fraud and integrity awareness briefings. The presentations included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and a question and answer session. The briefings were attended by 311 VAMC employees. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1, delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Managers are required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that is not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, Division employees assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA

programs and operations. Areas of particular interest to the division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, over-billing, false claims, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, compensation and pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** - Names, position titles, connection with VA, and other identifiers.
- **What** - The specific alleged misconduct or illegal activity.
- **When** - Dates and times the activity occurred.
- **Where** - Where the activity occurred.
- **Documents/Witnesses** - Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission, the person normally cannot be charged.

To Report Suspected Wrongdoing in VA Programs and Operations, Call the OIG Hotline -- (800) 488-8244.

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center Miami, Florida

Project Number: 2000-02974-R3-0009

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Reduction in excess inventory	$102,639	
Total		**$102,639**	

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: January 10, 2001

From: Director (546/00)

Subj: DRAFT REPORT: Combined Assessment Program Review – VA Medical Center, Miami, Florida (Project No. 2000-02974-R3-0009)

To: Assistant Inspector General for Auditing (52)
Thru: Network Director (10N)

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) Review of VA Medical Center Miami, Florida during the period of November 13-17,2000. The Miami VA Medical Center was appreciative of the constructive approach which proved informative and provided recommendations that will further improve the quality of care to our Veterans.

2. Our facility has reviewed the draft OIG report dated December 21, 2000 and provides our reply to the report findings and recommendations below:

A. Recommendation 1 – The VAMC Director should reduce inventories to 30-day levels.

Medical Center Director Comments – Concur. In accordance with VHA Handbook 1761.2 a Medical Center Policy has been drafted and is under review to mandate the use of the Generic Inventory Package (GIP) and Point of Use Technology (Attachment 1). Full implementation of GIP is expected to reduce supply on-hand levels through the availability of using data. This will enable the warehouse to accurately order the required stock and maintain optimal levels.

A wall-to-wall inventory of SPD inventory items was conducted utilizing the JANUS 2020 Bar Code Scanners and inventory records were updated to reflect the actual on hand data. Bar Code Scanners will be fully utilized to inventor all primary and secondary inventory points managed by SPD. Auto replenishment of ward closets using bar code scanners is expected to be complete by January 31, 2001. The target date for implementation of GIP and bar coding of all other managed inventory points is May 2001. Until full implementation is completed, the SPD staff are instructed to correct inventory discrepancies at the time errors are noted. This will allow for consistency of inventory data. Full implementation of Bar Coding Technology and GIP enable this facility to appropriately track inventory data and achieve the economy of having no more than the required 30-day level of stock on hand.

Medical Center Director Comments

2
Assistant Inspector General for Auditing (52)

B. Recommendation 2 – The VAMC Director should ensure that preventive maintenance is performed as required.

Medical Center Director Comments – Concur. At the request of the Inspector General's Team (IG Team), water from a filer (behind the ice/water machine in the Nursing Home) was submitted by Infection Control to the Microbiology Lab to perform a quantitative bacterial culture (Attachment 3). The waster from the filter grew 40 colonies/milliliter of *Pseudomonas aeruginosa*. This is within the limit of the National Primary Drinking Water Regulations up to 500 colonies/milliliter. The standard limits for fecal coliforms are zero. No coliforms were isolated from the water sample. The water proximal to the filter was cloudy and rust colored. The filter also had a rusty color. The color was thought to be secondary to rust in the pipes and the water sample was submitted for chemical analysis by the Industrial Hygienist to an independent laboratory.

On December 5, 2000 additional water samples were collected for quantitative cultures from three sites. One from the main water entrance in the Nursing Home. The other two from the water proximal and distal to the replacement filter of the ice machine. There was no bacterial growth from any of the three samples. The in-house preventive maintenance program and National Primary Drinking Water Regulations were reviewed. Revisions were recommended for two of the interventions beginning January 2001.

- The frequency of changing the filter must be increased to monthly, for NHCU.
- The filter housing must be disinfected by soaking it in a 2400 ppm (6oz. of bleach to 1 gal. of water) chlorine solution for 5 minutes, and rinsed well with tap water.

Bacterial and fungal cultures were also requested from the "caked" dust collected from an induction unit in the nursing home by the IG team. The cultures grew 30 colonies of *Bacillus sp.* And 10 colonies of *Aspergillus sp.* The quantities and type of microorganisms seen in the cultures listed above are low and expected when isolated from environmental cultures. To decrease the dissemination of dust and microorganisms starting January 2001 the routine maintenance of the ventilation system must include regular cleaning of the induction unit when changing the filter located distal to the induction unit.

Identifying potential environmental sources of microbes is a part of all Infection Control rounds. For the next twelve months, Facilities Management will report monthly to the Infection Control Committee the preventative maintenance listed above.

3. If you should require any additional information or clarification, please contact Terry S. Atienza, Executive Assistant to the Associate Director at (305) 324-3398.

T. C. DOHERTY

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