Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri

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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 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. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- We evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- We review selected financial and administrative activities to ensure that management controls are effective.
- We 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 of Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs (VA) Harry S. Truman Memorial Veterans' Hospital (HSTMVH) Columbia, Missouri. The CAP team visited the HSTMVH from July 17 to July 21, 2000. The purposes of the review were to evaluate selected hospital operations focusing on patient care and quality management, financial and administrative controls, and fraud prevention.

The HSTMVH is a general medical and surgical, tertiary care teaching medical center with 66 acute care operating beds and 38 extended care beds. The veteran population in the service area is approximately 96,000. Facility clinicians treated 6,537 unique inpatients and saw 148,422 outpatients in Fiscal Year 1999. Staffing totaled 816 full-time equivalent employees as of June 1, 2000, and the budget was $90.1 million.

Patient Care and Quality Management. HSTMVH management supported quality management (QM) and performance improvement. The hospital had a comprehensive, well managed QM program that effectively coordinated patient care activities and properly monitored patient care. However, some issues related to patient care oversight and employee communications needed management attention.

We suggested that the HSTMVH Director: (a) expedite QM program revisions; (b) implement a plan to assess, monitor, and document QM in community based outpatient clinics (CBOCs) to track and trend quality of care; (c) take appropriate action regarding the recommendations of the Cardiac Surgery Consultants Committee; (d) develop and implement a plan to provide employee training on women's issues at the CBOCs; (e) improve communications with employees regarding employees' perceptions that the awards and recognition program is not equitable and that the HSTMVH might be closed; (f) develop and implement a policy on the assessment and management of pain; and (g) ensure that HSTMVH staff members conduct periodic visits to community nursing homes as required.

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 HSTMVH Director: (a) monitor Medical Care Collection Fund activities to maximize collections; (b) ensure timely deobligation of accounts payable and undelivered orders so the funds can be better used; (c) ensure purchase card transactions are promptly reconciled and properly approved; (d) ensure controlled substance inspectors are not individuals who handle drugs as part of their routine duties; (e) limit access to the outpatient pharmacy vault as required; (f) conduct random Agent Cashier audits and reconcile opened mail remittances with the pharmacy mail registry log; (g) comply with printing service

termination action on an employee on Leave Without Pay and refer the employee's debts to the Internal Revenue Service for collection through tax refund offset.

Fraud Prevention. As part of our review, we provided Fraud and Integrity Awareness briefings to 140 HSTMVH employees.

HSTMVH Director Comments. The Director generally agreed with the CAP review findings. He provided acceptable plans to take corrective actions on all review issues except our suggestion that clinicians make required visits to community nursing home patients. (See Appendix II for the full text of the Director's comments.) Except for the community nursing home patient visit issue, we consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

Table of Contents

Introduction

Harry S. Truman Memorial Veterans' Hospital

The Department of Veterans Affairs (VA) Harry S. Truman Memorial Veterans' Hospital (HSTMVH) is a general medical and surgical tertiary care teaching facility. The HSTMVH is one of seven clinical care facilities in Veterans Integrated Service Network (VISN) 15. Community based outpatient clinics (CBOCs) are located at Fort Leonard Wood and Kirksville, Missouri. In partnership with VA Medical Center (VAMC) Kansas City, the HSTMVH has also established a CBOC at Whiteman Air Force Base, Missouri.

Affiliations and Programs. The HSTMVH is affiliated with the Missouri University School of Medicine with programs to train medical students, medical residents; and other programs including nursing, allied health, and health service management.

Resources. In Fiscal Year (FY) 1999, medical care expenditures for the HSTMVH totaled about $89.2 million, and the FY 2000 budget was $90.1 million. Staffing as of June 1, 2000, totaled 816 full-time equivalent employees (FTEE), including 44.2 physician FTEE and 239.0 nursing FTEE. The hospital's medical research program had 111 active projects and a budget of approximately $1.1 million.

Workload. Hospital clinicians treated 19,569 unique patients in FY 1999. Inpatient care was provided to 6,537 unique patients, with an average daily census of 56 patients in acute care beds and 32 extended care patients. In addition, the hospital had a total of 148,422 outpatient visits.

Objectives and Scope of the Combined Assessment Program Review

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 HSTMVH employees.

Patient Care and Quality Management (QM) Review. We reviewed selected clinical activities to evaluate patient care management and the QM program. 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. 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.

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

- Acute Care Medicine
- Physical Restraint Documentation
- Ambulatory Care Service
- Clinician Staffing
- Women's Veterans Program
- Acute & Long-term Mental Health
- Pain Management
- Geriatrics and Extended Care
- Physical Plant Maintenance
- Quality Management Program
- Contract Nursing Home Program
- Nutrition Service
- Pharmacy Service
- Surgical Service

Financial and Administrative Management Review. We reviewed selected financial and administrative activities, to evaluate 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 administrative, financial, and clinical records. The review covered the following financial and administrative activities and controls:

- Enhanced Use Leases
- Nursing Home Contracts
- Medical Care Collection Fund
- Agent Cashier Operations
- Means Test Certifications
- Equipment Purchases and Leases
- Employee Debts
- Accounts Receivable
- Purchase Card Program
- Inventory Management
- Drug Accountability
- Service Contracts
- Printing Practices
- Unliquidated Obligations

Fraud and Integrity Awareness Training. We conducted three fraud and integrity Awareness briefings for 140 hospital employees. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review generally covered HSTMVH operations for FY 1999 and FY 2000 through June 30. The review was done in accordance with the VA Office of Inspector General's (OIG's) standard operating procedures for conducting CAP reviews.

Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Programs Were Generally Effective

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

Management Showed a Commitment to QM. HSTMVH's management demonstrated a strong commitment to QM and performance improvement. Management supported continuing education for employees in such areas as performance improvement, QM, and supervisory skills. During interviews with patients, employees, and representatives from Veterans Service Organizations, positive comments were made about management being responsive to the concerns of the patients and providing feedback on any issues presented to them.

The Primary Care Product Line Had an Effective Performance Improvement Program. Over a period from January 1998 to July 2000, Primary Care Product Line managers collected data that demonstrated a decrease in the number of amputations due to complications of diabetes and a decrease in the number of admissions associated with the management of Chronic Obstructive Pulmonary Disease. Scheduling has been improved to make clinic time available to manage walk-in patients and provide patient appointments within 7 days of the request. Employees are allowed to attempt creative and innovative scheduling solutions. Patients stated that they were very pleased with the primary care services provided. HSTMVH's performance improvement program led the nation in compliance with clinical guidelines.

Most Patients and Employees Were Satisfied with the Quality of Care. We interviewed facility management, clinicians, clinical managers, 11 acute care patients, 11 long-term care (LTC) patients, and 96 outpatients. We also sent questionnaires to 260 randomly selected full-time employees, with 157 (60 percent) responding. The results of the interviews and surveys showed that patients and HSTMVH employees were generally satisfied with the quality of care provided by the facility. For example, 95 percent of the patients rated their overall quality of care as good, very good, or excellent. Similarly, 90 percent of the employees rated the quality of care provided to the patients as good, very good, or excellent. Of the patients whom we interviewed, 96 percent would recommend care at the HSTMVH to family members or friends. On the other hand, only 70 percent of the employees whom we interviewed and surveyed would make such a recommendation. Management should attempt to determine the reasons that employees have less confidence in recommending care at the HSTMVH to family members or friends.

Nutritional Assessment Management Was Well Conducted. We conducted a focused medical record review on Nutritional Assessment Management in LTC. We reviewed 10 medical records of the LTC patients on the unit to determine if clinicians had recorded their assessments and treatments of each patient's nutritional status. We concluded that in all cases timely nutritional assessments were done. Patients at nutritional risk were identified, and plans of actions were developed, implemented, monitored, and revised as needed.

The Need for Physical Restraints Was Properly Documented. We reviewed nine medical records to determine if clinicians had properly ordered and recorded needs for physical restraints, and if restraint use had been in compliance with the HSTMVH's policy. All nine medical records contained evidence of assessments by registered nurses prior to the initiation of restraints. The use of alternatives and outcomes of alternatives before initiation of restraints was also documented. Nursing documentation pertaining to restraint checks, release of restraints in accordance with policy, and an assessment of the patients for appropriateness of restraints removal was present in all nine medical records. There was also evidence in all nine medical records that LTC managers reviewed episodes of restraint use. Eight of the nine medical records contained evidence of time-limited physician orders for each restraint episode. One medical record contained documentation of a verbal physician's order. About 5 months before our review, clinical managers instituted a restraint and seclusion rights document that is read to each patient at the time of admission.

Mental Health Patients Had Timely Access to Primary Care. We reviewed 10 medical records to assess access to primary medical care for mental health patients. All 10 records contained evidence that primary medical care was provided to each patient. The patients can access their primary care providers in a timely manner through the triage team on the day shift and through Urgent Care during the evening and night shifts. All of the records contained evidence of physical examinations in the last year and annual psychosocial updates. Patients knew their primary care providers and can access primary care services at the CBOCs.

Managers Should Address Delivery and Quality of Certain Patient Care Services

Expedite QM Program Revisions. The QM program provided direction, coordination, and oversight of the hospital’s patient care services. The program included such activities as quality improvement, risk management, utilization review, infection control, employee in-service training, and patient representative services. We found that the QM staff collected meaningful data, but did not effectively communicate the results of their analyses and findings to clinical and line managers. Additionally, appropriate follow-up was not conducted on patient reports, focused reviews, and administrative investigations. Also, we found no evidence of interdisciplinary involvement in the quality improvement oversight process.

The QM coordinator told us that the program was being revised to reflect the facility's current performance improvement process. The coordinator stated that the revised process would ensure proper data collection, analysis, action item follow-up, and procedures to document improvement efforts. QM employees had recently received training on the root cause analysis process. In addition, process action teams will be developed to ensure that employees on all levels will be involved in the performance improvement process. We suggested that management expedite the planned revisions for the QM program.

The Director stated that reports generated by the QM staff are now being provided to appropriate clinical and administrative service line managers. A new performance improvement model restructured the QM program to ensure that both clinical and administrative leadership provide strategic direction and oversight. The Director's implementation plan is acceptable.

Include CBOCs in the Published QM Program. The HSTMVH has opened a CBOC at Fort Leonard Wood, and another CBOC in partnership with VAMC Kansas City at Whiteman Air Force Base. There is also a contract CBOC located in Kirksville. There are plans to open three additional CBOCs. The coordinator of the CBOCs told us that he visits each facility once a month to talk with the employees and conduct training. However, there was no formal process for assessing, monitoring, or documenting the quality of care in the CBOCs, and these tasks were not being performed. We suggested the Director develop and implement a QM program for the CBOCs. The Director stated that the CBOCs were included in the QM program, but he acknowledged that a written document containing the formal process for conducting the QM program at the CBOCs should be prepared. The Director's implementation plan is acceptable.

Take Appropriate Action Concerning The Cardiac Surgery Consultants Committee's Report. Two years ago the HSTMVH Cardiology and Cardiac Surgery programs were downsized in response to a reduction in the hospital's budget. Many employees expressed concern that downsizing the Cardiology and Cardiac Surgery programs had a negative affect on access and quality of patient care and employee morale.

In response to a request by the Under Secretary for Health, the VA Cardiac Surgery Consultants Committee visited VISN 15 and the HSTMVH on March 18-19, 1999. In their July 1999 report, the committee concluded that the HSTMVH's Cardiac Surgery program was more cost effective than the majority of the non-VA programs that VISN 15 was contracting with, and that it is very competitive with other VA Cardiac Surgery programs. The committee also reported that the lack of additional funding and/or referrals from the VAMCs in VISN 15 had resulted in a reduction in Cardiology and Cardiac Surgery staffing, which may have a negative affect on patient care. The committee made six recommendations to assist in strengthening the HSTMVH's Cardiology and Cardiac Surgery programs.

We were told that HSTMVH management had not received a copy of the committee's report. We suggested the Director obtain a copy of the Cardiac Surgery Consultant's Committee's report and, in coordination with VISN 15 management, take appropriate action regarding the recommendations. The Director stated that a copy of the report had been obtained and carefully reviewed. The Director described actions taken on two of the six recommendations that were applicable to HSTMVH, as well as actions taken in coordination with VISN 15 management to strengthen the Cardiology and Cardiac Surgery programs in the VISN. We consider the Director's comments responsive, however, we will follow up with VISN management regarding their actions in response to the recommendations in the Cardiac Surgery Consultants Committee's report.

Some Aspects of the Women Veterans Program Could Be Improved. Employee education on the special needs of women patients, outreach program expansion, and data collection from CBOCs on issues pertaining to women patients should be improved.

The Women Veterans Program at the main hospital appeared to be operating within established guidelines. However, CBOC managers were not reporting required information to the facility program manager. Due to time restraints, the manager of the Women Veterans Program had been unable to provide employees with training on special needs of women patients or conduct outreach programs. Data was not collected, tracked, or trended on the quality of care provided to women patients at CBOCs.

We suggested that the Director develop and implement a plan to provide employee training on women's issues and outreach to women patients at the CBOCs. The Director stated that efforts were underway to address some of the recognized issues with the Women Veterans Program. He stated that CBOC data specific to women's health issues was being collected, and it will be provided to the Women Veterans' Coordinator in a timely and consistent manner. Also, management will work with the Women Veterans' Coordinator to develop educational and outreach opportunities. The Director's implementation plan is acceptable.

Management Has Opportunities to Improve Employee Relations. Survey responses indicated that hospital employees were generally satisfied with their jobs. For example, 129 of 156 (83 percent) employees responding to our questionnaire reported that they gained personal satisfaction from their jobs. However, there was a perception among employees that the awards and recognition process was unfair. Of the responding employees, 123 of 152 (81 percent) did not believe awards adequately reflected their performance. We received many written and verbal comments about the HSTMVH receiving $250,000 from VISN 15 for outstanding facility performance in 1999. Employees perceived that this money was to be earmarked for the employee awards program. However, the funds were not earmarked for the employee awards program and were placed in the operating budget at the Director's discretion.

Several employees also reported that employees perceived that the HSTMVH might be closed. According to them, this assumption arose because of selected services and staff reductions at the facility. Some employees stated that they felt that management was aware that the HSTMVH would close, but would not let them know when it was going to happen. Also, employees reported people in the Columbia community told them that they were reluctant to seek employment at the facility since it might close.

The Director and some top managers expressed their concerns that funding constraints had reached the point at which some initiatives had to be curtailed, such as the employee awards and recognition program. No funds were allocated for awards and recognition in FY 2000. However, the Director told us that he usually allocates $80,000–$90,000 annually for the employee awards and recognition program, and that it is his desire to allocate money for this purpose in FY 2001. Management also told us that there are no plans to close the facility. We suggested that management improve communications with employees and address the employees' perceptions that the awards and recognition program was unfair and that the HSTMVH might be closed. The Director stated that $200,000 was allocated for the employee awards and recognition program in FY 2001. Also, the Director stated that he has created several avenues to allow staff to interact with top management, and he established a goal in the FY 2001 Hospital Strategic Plan to that end. The Director's implementation plan is acceptable.

A Policy on Pain Assessment Should Be Developed. We reviewed a sample of 10 active acute medical/surgical patients' medical records to evaluate documentation of pain assessments. The facility did not have a pain management policy, but we reviewed an electronic mail message, provided to us by management, that required clinicians to perform assessments of all patients using a 10-point pain rating scale. The nursing admission assessment forms included a question about the patients' levels of pain, but the forms did not use the 10-point pain rating scale. In five records, the patients reported pain when they were admitted, but only one of the five records discussed the patient’s subsequent pain or pain reassessments. On the other hand, the LTC unit was using a model for pain assessment that should be used throughout the facility. We suggested that clinical managers develop a facility policy addressing the assessment of pain, including the use of the 10-point pain rating scale. The Director stated that the medical center finalized a policy on pain management subsequent to the CAP visit. He also stated that the HSTMVH has participated in VA's Institute for Healthcare Improvement Initiative on Pain Management and has implemented strategies with very good results. The Director's implementation plan is acceptable.

Clinicians Should Visit Community Nursing Home (CNH) Patients. We reviewed CNH administrative and clinical oversight procedures and documents including CNH contract rates, CNH annual evaluations, and quality and appropriateness of patient care follow-up visits for 8 of 20 contracts in force during the CAP review. The HSTMVH had 26 CNH patients at the time of our visit. CNH contract rates were all established within existing guidelines, and hospital employees generally conducted annual CNH inspections.

Responsible VA staff members are required to visit every VA-sponsored CNH patient at least every 30 days. Also, at a minimum, a nurse must visit CNH patients at least every 60 days. HSTMVH social workers were visiting VA-sponsored CNH patients only once every 6 months, and no nursing follow-up visits were being conducted. The CNH coordinator told us that additional duties, including visits to housebound veterans and veterans in State Homes, do not allow enough time for the required visits.

We suggested that management ensure the quality of care in CNHs by requiring regular clinician visits at least every 30 days and by a HSTMVH nurse at least every 60 days. The Director did not agree to implement our suggestion and stated that in 1995 a decision was made to decrease the frequency of the routine visits due to limited resources, since the veterans were invariably receiving adequate care. Without fail the routine contact with the patient would not reveal any information that would result in a change to the plan of care nor indicate that the plan of care was not being followed. In lieu of the monthly visits, the Director stated that each veteran is given the name and telephone number of a social worker at the HSTMVH and instructed that immediate follow-up will be provided when requested. The social worker will visit each patient at least every 90 days. Also, the Registered Nurse reviews the plan of care for each veteran every month, reports any deficiencies, and makes site visits if deficiencies occur. We continue to believe that the quality of care in CNHs can be better ensured if required visits are conducted. We will refer this issue to VISN 15 and VHA management.

Financial and Administrative Management

Management Controls Were Generally Effective

Financial and administrative activities that we reviewed were generally operating satisfactorily, and management controls were generally effective, as evidenced by the following.

Enhanced Use Leases Were Appropriate. We reviewed 2 of the facility's 16 enhanced use leases to ensure that oversight was appropriate and that the revenues were adequate to cover all related VA expenses. We found that facility employees managed both leases appropriately, and that revenues exceeded related VA expenses.

Service Contracts Were Effectively Monitored. We reviewed contract oversight for four clinical service contracts and the ambulance contract. The total value of these contracts was about $893,000. All five contracts had Contracting Officer Technical Representatives appointed who were effectively monitoring contractor performance and ensuring compliance with the contract terms.

Equipment Procurements Were Properly Justified. We reviewed the acquisition and justification for five equipment items with an approximate value of $1.1 million. Equipment procurements had been properly analyzed and justified.

Vendor Accounts Receivable Were Well Managed. As of March 31, 2000, there were 23 vendor receivables totaling $74,611. To assess the facility's collection efforts, we reviewed 5 vendor accounts receivable, totaling $60,208, and found that Fiscal Service employees took prompt collection action.

Means Testing Activities Were Effective. Hospital employees properly entered means test information into the veterans' automated records and obtained signed means test disclosures.

Suggestions for Management Attention

Medical Care Collection Fund (MCCF) Activities Should Be Improved. VA is authorized to bill insurance companies or other third parties to recover the reasonable cost of medical care furnished to veterans for the treatment of nonservice-connected disabilities or conditions. MCCF management had established procedures and controls to improve collections by: (a) improving patient intake procedures to identify new insurance opportunities; (b) training employees on coding for reasonable charges; and (c) performing trend analyses and reviews for reduced payments and denials.

However, procedures for obtaining pre-authorizations for care and submitting timely claims for reimbursement to third party insurers needed to be improved. In addition,

controls to separate duties of receiving payments and writing off accounts receivables needed to be established.

- We reviewed 15 third party health insurance bills and identified 2 payments that were reduced $18,515 by the insurers because MCCF employees did not obtain pre-authorizations (authorizations for care prior to admission). MCCF employees did not know why pre-authorizations were not obtained for these two cases.

- Processing time for outpatient and inpatient third party billings and unbilled amounts has increased significantly. During the period from January to June 2000, the average billing time increased from 52 to 169 days and from 56 to 147 days for outpatient and inpatient billings, respectively. By comparison, the Hospital Accounts Receivable Analysis (HARA) report, a national private sector benchmark for hospital receivables, reported in September 1997 that the hospitals in their study averaged only 9 days to issue a bill. From January to June 2000, the unbilled outpatient care increased from $2.2 million to $3.9 million and unbilled inpatient care increased from $1.1 million to $1.4 million. MCCF managers stated that the reduction in collections was caused by the implementation of reasonable charges (amounts that third parties would pay for the same care or services furnished by public sector health care providers in the same geographic area). Implementation of reasonable charges requires that the exact care provided must be determined, coding must be accurate, and separate bills must be generated for each episode of care. Before the implementation of reasonable charges, billings were based on a fixed rate or per diem.

- MCCF employees were able to both accept payments and write off the accounts receivable for third party payer reimbursements. These duties should be separated to maintain adequate fiscal control. MCCF managers stated that the limited number of staffing resources does not currently allow them to separate these duties. However, the addition of new employees, which is expected in the near future, will allow for improving these fiscal controls.

We suggested that the Director actively monitor these three areas and take appropriate action to maximize collections and enhance fiscal controls. The Director stated that we failed to recognize the negative impact of vacancies in coding and billing resulting from recruiting difficulties and turnover in MCCF staffing. The Director stated that, even with those problems, they have made improvements in leadership and the reporting structure. In addition, the VISN conducted audits to further improve operations. The Director stated that corrective action had been taken regarding the three areas of concern discussed above. The Director's implementation plan is acceptable. Regarding the statement that we failed to recognize the negative impact of staff shortages, as stated above, we reported that MCCF managers told us that limited staffing resources prevented separation of duties. We also reported that MCCF managers told us billing processing time had increased as a result of the implementation of reasonable charges. Our recognition of these problems was the reason we suggested that the Director actively monitor the three areas and take appropriate actions.

Funds Management Can Be Improved By Timely Canceling Invalid Obligations. Fiscal Service should analyze accrued services payable (ASP) and undelivered orders (UDO) reports monthly to identify outstanding payables and delinquent orders that can be cancelled. Payables are outstanding and orders are delinquent if the obligation is more than 90 days old. Fiscal Service should contact the service that initiated the payable to determine whether the obligation is still valid. If it is not valid, Fiscal Service should cancel the obligation and reprogram the funds.

We assessed 40 obligations valued at $314,179 as of May 31, 2000 consisting of a sample of 20 ASPs valued at $259,387 and 20 UDOs valued at $54,792.

- Two ASPs valued at $790 were not valid and should be deobligated.

- Five UDOs valued at $15,450 and should be closed.

We suggested the Director ensure that funds that can be deobligated are identified as soon as possible so they can be put to use. The Director stated that subsequent to our review, the list of ASPs and UDOs is reviewed within 60 days to allow for action by the administrative contracting officer. According to the Director, the list is now smaller and more manageable, resulting in improved outcomes. The Director's implementation plan is acceptable.

Purchase Card Transactions Should Be Promptly Reconciled and Properly Approved. VA medical facilities are required to use government purchase cards for small purchases of goods and services (usually $2,500 or less). The purchase card program at HSTMVH included 70 purchase cardholders and 21 approving officials. From October 1, 1999, to May 31, 2000, purchase cardholders processed 7,106 transactions totaling approximately $3.2 million.

Cardholders are required to reconcile charges within 5 days of data entry into the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system to ensure that the charges billed are accurate. The cardholder must match the estimated amount of the purchase with the amount billed, reconcile differences, ensure receipt of the goods ordered, and provide the approving official with applicable receipt records. The approving official must then certify the reconciled payment charges in IFCAP within 14 days of receipt from the cardholder. The certification ensures purchases are within the cardholder's assigned limits, purchases have applicable supporting documentation, and purchases over $2,500 are not split to stay within monetary limits. VA loses the ability to recover erroneous or inappropriate charges from the credit card company, if the charges are not disputed within 60 days.

Our analysis of purchase card transactions processed from October 1, 1999, to May 31, 2000, showed that charges were not reconciled or certified in a timely manner. Cardholders did not reconcile 2,177 of 7,106 (31 percent) of the transactions within the required 5-day time frame. Delinquent reconciliations ranged from 6 to 255 days

totaling approximately $1 million. Approving officials did not certify 1,200 of 7,106 (17 percent) of the transactions, totaling nearly $450,000, within the required 14-day review and certification period. Delinquent certifications ranged from 15 to 240 days.

In addition, we identified a minor deficiency in the program coordinator's responsibilities. The Purchase Card Coordinator was the approving official for four purchase cards. VHA policy states that the coordinator cannot be a cardholder or approving official. We discussed this with the coordinator, and he appropriately delegated the approving official responsibilities for these four cards to the Human Resources Liaison.

We suggested the Director monitor timeliness of purchase card reconciliations and certifications and follow up with frequently delinquent cardholders and approving officials. The Director stated that the data associated with many of the late reconciliations and approvals that we identified were either misleading or in error. He indicated that software problems caused the reconcilations and approval dates to be erroneous. The Director also said that, at the time of our review, they were in the process of cleaning up old, erroneous orders, and this process added to the delinquent time frames that we identified. To ensure timely reconciliations, the Director stated they are now running the Unapproved Austin Payment Transactions report more frequently and are sending reminders to those credit card holders who have not reconciled within the new 10-calendar day time frame. The Director's implementation plan is acceptable. The Director's conclusion that software problems caused erroneous reconcilation and approval dates for the purchase card transactions we reviewed apparently resulted from analyses performed after we left site. Had the reconciliations and approvals been accomplished when required, any software problems causing misleading or erroneous data would have been identified before our review. The Director's corrective action should ensure purchase care transactions are promptly reconciled and properly approved.

Controlled Substance Inspections Should Be Improved VAMCs are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The purpose of these inspections is to ensure that the VAMC is properly accounting for controlled substances. The inspectors must be VA employees who do not handle drugs as part of their routine duties. Inspectors should physically count the quantities of controlled substances and reconcile these quantities to perpetual inventory records. If any shortages are noted, they must be reported to the VAMC Director, who must ensure that the shortages are investigated.

We noted two deficiencies in the inspection process. First, 2 of the 13 inspectors were VA employees who handled drugs as part of their routine duties. One inspector was a pharmacy technician and the other was a nurse. VHA policy states that inspectors should not be pharmacists, nurses, physicians, or supply officials. Second, inspectors were not reviewing medical records to ensure that doctors' orders existed for the drugs administered to patients. VHA policy and facility policy require inspectors to review a sample of dispensing entries to ensure a valid doctor's order is in the patient's chart. The Controlled Substance Officer agreed to review medical records for doctors' orders

in future inspections. We suggested that the Director ensure inspectors are not individuals who handle drugs as part of their routine duties. The Director stated that the Controlled Substance Officer has replaced the two inspectors in question with employees who do not handle drugs as part of their routine duties. The Director's implementation plan is acceptable.

Access to Controlled Substances Should Be Limited. VAMCs are required to limit the number of pharmacy employees who have access to scheduled drugs in the pharmacy to less than 10 employees per storage site. Our review of individuals with access to the outpatient pharmacy controlled substances vault showed that 16 pharmacists and 2 technicians had access to the vault where controlled substances are stored and dispensed. The Director stated that limiting access to the pharmacy vault to 10 employees will require two storage areas. A construction project to accomplish this initiative will be developed and incorporated into the hospital's long range construction program. The Director's implementation plan is acceptable.

Unannounced Agent Cashier Audits Need Enhancements. VA facilities are required to conduct unannounced audits of the Agent Cashier's advance and undeposited collections at least every 90 days. Additional audits may be prescribed if considered necessary. The dates and times of unannounced audits should randomly vary to prevent the establishment of a pattern. Audits are required to include a reconciliation of cash received in the mail and recorded in the mail registry log and the cash receipts collected by the Agent Cashier since the last audit.

We analyzed the Agent Cashier advance's turnover rate and found the advance level to be appropriate. However, employees conducted the five most recent unannounced audits during the first full week of the month following the end of each quarter. This pattern nullifies the element of surprise. We also found that unannounced audits did not include reconciliation of opened mail remittances received by the pharmacy to the pharmacy mail registry log. The Director agreed to conduct the audits more randomly and to reconcile opened mail remittances with the pharmacy mail registry log. The Director's implementation plan is acceptable.

Printing Service Procurements Should Adhere to Regulations. Federal agencies are required to procure printing through the Government Printing Office (GPO), unless the procured services are in a class of work, which cannot be provided more economically through GPO. For example, business cards are required to be procured through a specific General Services Administration contract. GPO may grant a waiver if it cannot meet certain requirements for a particular printing request. VA regulations require that facilities report these waivers semiannually to VA Central Office (VACO).

We reviewed the practices and procedures for 68 printing service procurements totaling $40,865 during the period October 1, 1998, to June 30, 2000. We found that Business Operations Service complied with GPO requirements for 54 printing service procurements totaling $37,675. However, the service did not submit the remaining 14 printing service procurements totaling $3,190 to GPO or obtain waivers. This occurred

because the service believed that GPO requirements did not apply to these 14 projects based on the individual dollar amounts. We contacted GPO customer care employees and determined that the Business Operations Service should have submitted these 14 projects to GPO or requested waivers.

We also found that the waivers obtained for FY 1999 were not reported to VACO. This occurred because Business Operations Service was not familiar with this requirement. The Director stated the HSTMVH will comply with requirements on all future printing services procurements. The Director's implementation plan is acceptable.

Collection Efforts for Employee Accounts Receivable Should Be Improved. VA policy states that erroneous pay, allowance debts, or other nonbenefit debts owed by Federal employees to VA may be collected by offset from current salary, final salary, lump sum payment, and retirement system accounts. The policy also states that a former Federal employee's (ex-employee) debt may be referred to the Internal Revenue Service (IRS) for tax refund offset collection.

As of March 31, 2000, the universe of employee and ex-employee accounts receivable was 18 receivables totaling $12,877. We reviewed a sample of 5 accounts receivable, totaling $5,418, and found that Fiscal Service pursued these accounts receivable through the use of collection letters, telephone calls, and other correspondence.

Three receivables totaling $3,724 as of July 19, 2000, involved one employee who was on Leave Without Pay (LWOP). This employee elected to continue health insurance coverage while on LWOP and to incur a debt for the amount of the unpaid premiums. The debt was never repaid, although Fiscal Service had appropriately pursued the receivables and taken follow-up action. We determined that Human Resources Service should have terminated this employee nearly 2 years earlier, when it became evident that the employee would not return to work. If the employee had been terminated timely, Fiscal Service could have referred these accounts receivable to the IRS for tax refund offset collection at an earlier date.

This employee was still on LWOP at the time of our review. The Personnel Management Specialist acknowledged that Human Resources Service had not monitored the employee's situation and should have terminated the employee from LWOP status earlier. After we identified the problem, the Personnel Management Specialist agreed to begin termination action for this employee immediately. Once the employee is terminated, Fiscal Service can refer the three receivables to the IRS for tax refund offset collection. The Director stated that the paperwork required to terminate the employee had been prepared and forwarded to the Network Business Office for final processing before we departed the station. The Director's implementation plan is acceptable. The Director also stated that part of the delay in finalizing the action on this individual had to do with awaiting a decision from the Merit Systems Protection Board. However, based on the records provided to us, we still believe, and the Personnel Management Specialist agreed, that the process should have been concluded much earlier.

Fraud and Integrity Awareness Briefings

As part of the CAP review, we conducted three fraud and integrity awareness Briefings at the HSTMVH. The briefings, attended by 140 employees, included a lecture, a short film presentation, and a question and answer session. Each session lasted approximately 75 minutes. 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 Office of Investigations – Administrative Investigations Division. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that are not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a VA official.

Referrals to the Office of Investigations – Criminal Investigations Division. 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, theft and 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 very 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 charge.

To report suspected wrongdoing in VA programs and operations, call the OIG Hotline – (800) 488-8244.

HSTMVH Director Comments

February 21, 2001

Director, HSTMVH, Columbia, MO (DIR)

Response to Draft Report of CAP Review

Director, Kansas City Audit Operations Division

1. We appreciate the opportunity to provide the following comments on the areas requiring management attention as indicated in your draft report dated December 22, 2000.

a. **Patient Care and Quality Management Review**

(1) Top Management Showed a Commitment to QM

We agree there is a high level of commitment to Quality Management at HSTMVH. Recent restructuring and refinement of our Performance Improvement program places heightened leadership involvement in designing strategic direction and ongoing oversight.

(2) The Primary Care Product Line Had an Effective Performance Improvement Program

We agree with your assessment that Primary Care (PC) has an effective PI program. Medical documentation of randomly selected patients is reviewed each month by EPRP along with PC Managers for compliance for compliance with Prevention Index and Chronic Disease Indicators. Results of the monthly review are shared with the PC providers. We have demonstrated consistent compliance to clinical performance measures over the past three years. In addition, clinic availability is monitored and actions taken to meet patient needs.

(3) Most Patients and Employees were Satisfied with the Quality of Care

In the last 'One VA' survey, 76% of the 609 respondents to the survey rated the overall quality of service provided to our veterans as good to very good. This was based on a rating scale of very poor to very good. Ninety-four percent rated the quality of services to be fair to very good. Based on your recommendation, we will attempt to address the staff confidence issue raised.

HSTMVH Director Comments

(4) Nutritional Assessment Management Was Well Conducted

We concur with your assessment of the nutritional assessment in LTC.

(5) Physical Restraint Was Properly Documented

Restraint (and seclusion) remains a continued focus for this facility. Revisions to hospital policy have been made to incorporate new JCAHO requirements and assure ongoing monitoring of restraint events.

(6) Mental Health Patients Had Timely Access to Primary Care

We concur with the findings in this section of the draft report.

b. **Managers Should Address Delivery and Quality of Certain Patient Care Services**

(1) Expedite QM Program Revisions

Reports generated by the QM staff, e.g. Risk Management, Quality Management, Utilization Management, Customer Service, etc., are currently provided to the appropriate clinical and/or administrative service line managers within established time frames. It is the expectation that these reports are reviewed, distributed to staff within the service line and discussed. Our new PI model was reviewed during a JCAHO mock survey in October 2000 and received favorable feedback. The goal of the restructuring was to assure that both clinical and administrative leadership provides the strategic direction and oversight for performance improvement initiatives. We believe that interdisciplinary involvement is now evident in the 'quality improvement' oversight process. The Clinical Executive Board (Executive Committee of the Medical Staff) and the Management Council provide oversight. These councils are comprised of clinicians and administrative staff. (See attachment)

(2) Include CBOCs in the QM Program

CBOCs are included in the 'QM Program.' Monthly External Peer Review is performed on a random review of patients at the CBOCs for management of Diabetes, Ischemic Heart Disease, COPD, Major Depressive Disorder, Congestive Heart Failure, Hypertension, Schizophrenia and Tobacco Cessation. Additionally, monthly random review of the preventive health measures of influenza and pneumococcal vaccines, screening for colorectal, cervical, breast and prostate cancer, tobacco screening and alcohol screening is also performed by external peer review. Complaints specific to CBOC patients are reported to the Patient Advocate and communicated to the appropriate service line director quarterly. All congressional correspondence specific to a CBOC patient is addressed and, when appropriate, peer review performed with results

discussed with appropriate clinician(s)/staff. Admissions within three days of an ambulatory care visit (which includes CBOC patients) are reviewed as part of the QM occurrence screening program. Any case not meeting criteria is referred to peer review. CBOC patients are included in the national customer service satisfaction survey as well as local customer service initiative. Feedback is provided. Quarterly site inspections that address infection control, safety and environment of care are performed. We agree that we should 'formalize' this in a written document.

(3) The Cardiac Surgery Consultants Committee's Report Should Be Obtained

The Cardiac Surgery Consultants Committee's report has been obtained and carefully reviewed by the Chief of Staff. In regard to the specific recommendations included in the report:

(a) Recommendation 1 - "Contracting out of cardiology and cardiac surgery cases except for emergencies...should be discontinued." *This is not applicable to our facility, however, we are a participant in the Network's strategic planning initiative addressing cardiology/cardiothoracic services.*

(b) Recommendation 2 - "Funds...need to be redirected." *Although this also is not applicable to our facility, we have always had intra-VISN transfer pricing for services provided. Additionally, as above, we are a participant in the Network's strategic planning initiative addressing cardiology/cardiothoracic services.*

(c) Recommendation 3 - "A conflict resolution team should be appointed" to improve relationships between leadership of VISN 15, our facility and the University of Missouri Health Sciences Center (UMHSC). *We do not agree with this statement. Perceptions, rather than fact, have influenced this assessment. In fact, at this time, we are participating with leadership of VISN 15 and UMHSC in a Partnership Study, facilitated by the Lewin Group, which is intended to identify formal collaborative opportunities.*

(d) Recommendation 4 – "The Harry S. Truman VAMC must continue their efforts of developing...more economies of scale and cost effective care." *This is a continual, on-going process. Examples include: we have consolidated intensive care units and wards to improve staff efficiency, continually attempt to improve purchasing arrangements and recently have added an ICU nurse educator to ensure staff are adequately trained.*

(e) Recommendation 5 – "The Harry S. Truman VAMC must further...improve access and user friendliness of their services." *In February 1999, we initiated a program to provided lodging for the spouse/significant other of patients referred to our facility for cardiac services; however, this service was suspended in mid-*

2000 due to expense. We can resume this benefit if the referral program resumes from previous levels. However, this is dependent on the hiring of additional ICU nurses.

(f) Recommendation 6 – "Since...services rendered at the Harry S. Truman VAMC are a valuable resources...it is only right for some of these costs to be shared." *Although this also is not applicable to our facility, as above, we have always had intra-VISN transfer pricing for services provided.*

(4) Some Aspects of the Women Veterans Program Could Be Improved

Efforts are underway both nationally and within VISN 15 to address some of the recognized issues with the Women Veterans' Program. Currently we have a RNP designated as the Women Veterans' Program Coordinator. She is allocated five hours per week to coordinate activities and provide employee and veteran education in the area of women's issues. It is our responsibility to ensure that she utilizes the time designated for that purpose. We are aware, however, that this is a recognized problem across the nation in instances where the duties are collateral. The VISN 15 Women Veterans' Program Coordinator confirmed this to be an identified problem in our VISN that is being addressed. On October 13, 2000 an annual meeting of women veterans was held at this facility. There were 75 women in attendance. Focus groups were held to identify key issues and to assess satisfaction. The results of the focus groups and/or survey identified the need to provide sexual trauma counseling outside any other group counseling activities. A dedicated sexual trauma counseling session is now offered. There are initiatives underway to develop and utilize clinical reminders specific to women's issues. Currently clinical reminders are in place for breast and cervical screening. A clinical reminder for military sexual trauma will soon be available to all *clinicians. Additionally, once VISN 15 database integration is completed (anticipated April 1, 2001), the compatibility issue between the Women's Health Database computer program and VistA will be resolved, eliminating the need for manual entry by clinicians and clerical staff. CBOC data specific to women's health issues is being collected. We will ensure that the data is provided to the Women Veterans' Coordinator in a timely and consistent manner. We will work with the Women Veterans' Coordinator, both locally and at the VISN, to develop educational and outreach opportunities.*

(5) Management Has Opportunities to Improve Employee Relations

The recommendation "Management Has Opportunities to Improve Employee Relations" is a generic statement which can apply to any organization. As stated, our satisfaction survey results indicated that a very high percentage of our employees (83%) gain personal satisfaction from their jobs. This is especially high considering all of the dramatic physical and organizational changes occurring at our hospital over the last few years. Awards were curtailed out of operational necessity for one year only. $200,000 was allocated for the employee reward and recognition program in FY 2001. We have always worked very hard on providing open communication with our staff and while

rumors have persisted over the last several years at our hospital due to on-going downsizing of in-patient activities, we have always addressed rumors openly and directly and will continue to do so. We have created several avenues to allow staff to interact with top management, including anonymous e-mail, suggestion boxes, employee newsletter articles, town hall meetings, etc. In our continued effort to improve communication between management and employees, we established the following goal in our FY 2001 Hospital Strategic Plan: "Deliver exceptional health care as measured by VHA performance measures with particular emphasis on employee development and management interaction with staff." An objective under this goal is: "Establish schedule for "walk-throughs" by executive management officials and attendance at Service Line meetings."

(6) A Policy on Pain Assessment Should be Developed

We had a draft policy at the time of the IG survey, unfortunately it was not presented for review. Subsequently, the policy has been finalized and signed. During the past year we have been a participant of the VA's Institute for Healthcare Improvement (IHI) Initiative on Pain Management and have implemented strategies with very good results.

(7) Clinicians Should Visit Community Nursing Home (CNH) Patients

In 1995, a decision was made to decrease the frequency of the routine monthly visits to Contract Nursing Homes due to limited resources. It was found that the Registered Nurse (RN) visits were not an effective use of resources since the veterans were invariably receiving adequate care. During the visits, the RN would talk to the veteran and review the written plan of care. Without fail, the routine contact with the patient would not reveal any information that would result in a change to the plan of care nor indicate that the plan of care was not being followed. We then placed the following plan into action, which we continue to follow:

1. *When a veteran is placed in a CNH, the veteran is given the name and telephone number of their Extended Care Social Worker at our VA Hospital.*
2. *The veteran is instructed to contact the social worker with any questions or concerns, who will initiate immediate follow-up.*
3. *The social worker performs follow-up visits to the CNH at a minimum of every 90 days.*
4. *The CNH mails the plan of care on each veteran to our hospital on a monthly basis. A RN reviews the plan of care and reports any deficiencies.*
5. *If any deficiencies are noted, the RN initiates a site visit.*
6. *The RN, social worker, and safety officer conduct an annual review of each CNH.*

While the above does not meet the letter of VA Manual M-5, we continue to believe this plan is the most effective use of our limited resources, while ensuring good patient care.

HSTMVH Director Comments

c. **Financial and Administrative Management**

(1) Management Controls Were Generally Effective

(a) Enhanced Use Leases Were Appropriate
(b) Services Contracts Were Effectively Monitored
(c) Equipment Procurements Were Properly Justified
(d) Vendor Accounts Receivable Were Well Managed
(e) Means Testing Activities Were Effective

We concur with findings c. (1) (a) through (e) of the draft report.

(2) Suggestions for Management Attention

(a) Medical Care Collection Fund (MCCF) Activities Should Be Improved

While improvements, as shown below, have been made in the structural reorganization and work flow assignments of this area, the IG failed to recognize the negative impact due to our previous and continued vacancies in coding and billing, which are a result of our inability to recruit, heavy turnover in MCCF staffing, and difficulty in replacing vacancies. Program area leadership has been changed and the reporting structure reorganized. MCCF now reports directly to the Chief Fiscal Officer. Additionally, coding has been realigned to reflect the same supervisory chain. An preliminary audit in December 2000 and an in-depth audit from January 8 through 12, 2001 of the MCCF and HIMS functions was conducted by VISN personnel to further define areas for improvement. The in-depth audit indicated that the steps taken to improve operations have already resulted in significant improvement. We have also identified several additional areas for improvement and anticipate that these will be completed within the next few months. Regarding the three specific areas of concern which were identified in the report, we make the following comments:

- *Pre-authorization – Implemented changes, coupled with recent training, will ensure that pre-authorization is accomplished in all cases.*

- *The audit and implemented changes have also focused on improvements in both lag time for processing billings and their unbilled amounts.*

- *MCCF employees are no longer allowed to accept payments and write off receivables.*

HSTMVH Director Comments

(b) Funds Management Can Be Improved by Timely Canceling Invalid Obligations

Presently, lists including Accrued Services Payable (ASP) and Undelivered Orders (UDO) are reviewed within 60 days to allow for action by the administrative contracting officer, who contacts the initiator of the request. Action is noted on the list and given back to the Accounting Section, which is then responsible for changing delivery dates on certifieds. This list is now smaller and more manageable, resulting in improved outcomes.

(c) Purchase Card Transactions Should Be Promptly Reconciled and Properly Approved.

On further review, we have determined that much of the data regarding purchase card transactions reviewed by the IG was either misleading or in error. On the majority of the orders the IG auditors reviewed, the reconciliations had been edited or removed for various reasons. When the charges were reconciled, the computer program counted back to the date the original charge came through. This occurs when a credit is received and the reconciliation has to be re-opened, or when there is an additional charge that the cardholder is unaware of and the original reconciliation has to be re-opened. This also changes the time it takes for the approving official to approve the reconciliation. Any time the reconciliation has to be edited or removed, the Approving Official has to re-approve the reconciliation and the computer program counts back to the date the transaction originally came through to reconcile. This appears to be a software problem.

Another complicating factor is that we were answering "no" to the "Final Charge" prompt until all items were received and would then edit the reconciliation to say "yes" to the "Final Charge" prompt, which would then send the reconciliation to the Approving Official. As outlined above, this again counted back to the original date the transaction came through, resulting in a delinquent obligation. If the "Final Charge" field was not edited after the product was received, by the time the charge was finally edited and finaled, it was delinquent. To resolve this problem, we are now answering "yes" to the "Final Charge" when all charges are received complete and then put in a pending file to ensure all items are received or charges disputed back to the credit card company if items are not received. At the time of the audit, we were also in the process of cleaning up old orders that were not signed in, that were reconciled to the wrong purchase order numbers, etc. This clean-up process added to the delinquent reconciliation/ approval time frame, as many of these also had to be edited or removed. To ensure timeliness of purchase card reconciliations, we have been running the Unapproved Austin Payment Transactions report more frequently and sending reminders to those credit card holders who have not reconciled within the new ten-calendar-day time frame.

HSTMVH Director Comments

(d) Controlled Substance Inspections Should Be Improved

The Controlled Substance Officer (CSO) has replaced two of the inspectors (a pharmacy technician and a nurse) with employees who do not handle drugs as part of their routine duties.

(e) Access to Controlled Substances Should Be Limited

While we agree with the recommendation, current resources do not allow an immediate solution nor does history indicate this to be an urgent matter. We have operated in our current configuration for many years without incident. To meet the requirement of limiting access to the pharmacy vault to 10 employees will require two storage areas: a working vault with a 1 to 7-day inventory, and a second area for the remainder of the bulk stock with very limited access. This solution requires the purchase and installation of an approved safe/vault of sufficient size to store the stock and an alarm system and method to document who enters and the time entered. A construction project to accomplish this initiative will be developed and incorporated into the hospital's long range construction program.

(f) Unannounced Agent Cashier Audits Need Enhancements

As recommended in the draft report, we are now conducting audits on a more random basis. We are also reconciling opened mail remittances with the Pharmacy mail registry log. We believe we are now in full compliance with VA Handbook 4010.

(g) Printing Service Procurements Should Adhere to Regulations

As a result of the realignment of services within Business Operations, the Commercial Printing Report was not being reported to Headquarters semi-annually. We are now aware of this requirement and are in compliance. We also reminded all credit card holders of the requirement to purchase all printing from the Government Printing Office.

(h) Employee Receivables Collection Efforts Should Be Improved

Even before the IG audit team departed our station, the paperwork required to terminate the employee on LWOP status had been prepared and forwarded to the Network Business Office for final processing. Part of the delay in finalizing the action on this individual had to do with awaiting a decision from the Merit Systems Protection Board.

HSTMVH Director Comments

2. We appreciate the opportunity to provide comments on the draft report. If there are questions or if additional information is needed, please contact Gary Langley, Acting Associate Director, at 573/814-6301.

Sincerely,

/signed/

GARY L. CAMPBELL

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