Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the Houston VA Medical Center Houston, Texas

Report No. 03-01379-115 **June 19, 2003**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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Executive Summary

Introduction

During the week of April 21–25, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Houston VA Medical Center (VAMC), which is part of Veterans Integrated Service Network (VISN) 16. The purpose of the review was to evaluate selected healthcare system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 322 VAMC employees.

Results of Review

VAMC patient care, QM, financial, and administrative controls reviewed were generally operating satisfactorily. To improve operations, the VAMC needed to:

- Reduce excess medical, prosthetic, and engineering supply inventories and strengthen inventory management controls.
- Post alerts in VAMC computer systems about potentially violent patients.
- Restrict laboratory access to authorized personnel.
- Correct medical procedure coding and insurance billing errors.
- Ensure that purchase cardholders have proper warrants.
- Correct and update equipment inventory lists.
- Improve procedures for reviewing and certifying contractor invoices.
- Ensure that computer access is terminated for former employees.

VISN 16 Director and Houston VAMC Director Comments

The VISN 16 Director and the VAMC Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes B and C, pages 12-19, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. The VAMC is a tertiary care center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two outpatient clinics (OPCs) in Lufkin and Beaumont, TX. The VAMC is part of VISN 16 and serves a population of 432,195 veterans in a primary service area that includes 27 counties in Texas and 4 parishes in Louisiana.

Workload. In Fiscal Year (FY) 2002, the VAMC treated 66,748 unique veterans, a 9.8 percent increase from FY 2001. VAMC management attributed the increase in unique veterans treated to the continuing population growth in the Houston area, the closure of several local health maintenance organizations, and the increasing number of veterans who are turning to VA for most or all of their medical care in order to use VA pharmacy benefits. The FY 2002 inpatient average daily census (ADC), including nursing home patients, was 414. For FY 2003 through March 2003, the ADC was 410. Outpatient workload totaled 610,271 patient visits in FY 2002 (a 7.2 percent increase from FY 2001) and 312,278 visits in FY 2003 through March 2003.

Resources. The VAMC's FY 2003 medical care budget was $345.7 million, a 10.3 percent increase over the FY 2002 budget of $313.3 million. FY 2003 staffing through March 2003 was 2,620.3 full-time equivalent employees (FTEE), including 188.4 physician and 662.1 nursing FTEE. FY 2002 staffing was 2,610.5 FTEE, including 186.8 physician and 676.8 nursing FTEE.

Programs. The VAMC provides medical, surgical, mental health, geriatric, and comprehensive rehabilitation services. The VAMC has 352 hospital beds and 120 nursing home beds and operates several regional referral and treatment programs, including a Spinal Cord Injury Unit. In addition, the VAMC provides services and conducts research at a Health Services Research and Development Center; a Mental Illness Research, Education and Clinical Center; and a Parkinson's Disease Research, Education and Clinical Center. The Veterans Health Administration (VHA) has designated all three programs as Centers of Excellence.

Affiliations and Research. The VAMC is affiliated with the Baylor College of Medicine and supports about 170 medical resident positions in 31 training programs. In FY 2002, the VAMC research program had 413 projects and a budget of $18.3 million. Important areas of research include mental illness, Parkinson's disease, treatment of stomach ulcers, and management of cardiac stenosis.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care system operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered VAMC operations for FY 2002 and FY 2003 through March 2003 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 18 activities:

Accounts Receivable	House Staff Disbursement Agreement
Community Based Outpatient Clinics	Information Technology Security
Community Nursing Home Contracts	Laboratory Security
Controlled Substances Accountability	Management of Violent Patients
Enrollment and Resource Utilization	Medical Care Collections Fund
Environment of Care	Pharmacy Security
Equipment Accountability	Quality Management
General Post Funds	Service Contracts
Government Purchase Card Program	Supply Inventory Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–10). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and VAMC management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, 260 of whom responded. We also interviewed 67 patients during the review. The survey and interview results were discussed with the VAMC Director.

During the review, we also presented 4 fraud and integrity awareness briefings that were attended by 322 VAMC employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Organizational Strengths

The QM Program Was Effective and Comprehensive. The VAMC had an effective QM program to monitor quality of care using national and local performance measures, patient safety management, and utilization reviews. QM staff thoroughly trended and analyzed data and effectively used graphics to report results. The peer review process was very detailed and integrated to evaluate care provided by both nurses and physicians. The mortality review was exceptional, with every case trended by ward, service line, day of the week, time, and provider. This tracking mechanism gave VAMC management the ability to identify and investigate any unexplained increases in mortality. The VAMC held a Performance Improvement Quality Fair with more than 50 poster presentations that represented performance improvement initiatives throughout the medical center. Performance improvement was evident in all service lines, with active involvement from front-line employees as well as managers.

Vendor and Employee Accounts Receivable Were Aggressively Pursued. The VAMC's Financial Resource Section (FRS) had effective controls for identifying and pursuing delinquent vendor and employee accounts receivable. We reviewed pertinent records for the 4-month period November 2002–February 2003 and found that FRS staff had properly verified the accuracy of billed, collected, and delinquent receivables by reconciling the General Ledger to subsidiary accounting records. We also evaluated collection efforts for 28 receivables over 90-days old (value = $93,844) and found no deficiencies. Receivables with recovery potential were aggressively pursued, and receivables that did not have recovery potential were promptly written off as uncollectible.

The Beaumont OPC Was Well Managed and Controls Were Effective. The Beaumont OPC had effective programs to monitor financial and administrative activities and had sound management controls in place. Means test certifications were obtained from veteran-patients, and notices for annual recertifications were sent out when required. Patient wait times for follow-up appointments were below the VHA goal of 30 days. Employees who held Government Purchase Cards had been properly trained and were using the cards appropriately. OPC lease and service contract prices were reasonable, and contract files included all required documentation.

Nursing Home Contracts Were Reasonably Priced. As of February 2003, the VAMC had 28 contracts (combined costs = $425,228) to provide care for VA patients at community nursing homes located throughout Texas. We reviewed the files for five contracts and found that they were well organized and contained all required documentation. Contract prices were based on Medicaid rates plus 15 percent or less, which is below VA's benchmark of Medicaid plus 18 percent. VAMC employees were also conducting annual nursing home inspections as required.

Opportunities for Improvement

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Conditions Needing Improvement. The VAMC needed to reduce excess inventories of medical, prosthetic, and engineering supplies and make better use of automated controls to more effectively manage supply inventories. In FY 2002, the VAMC spent $22.1 million on medical, prosthetic, and engineering supplies. The VHA Inventory Management Handbook establishes a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Medical Supplies. Supply, Processing, and Distribution (SPD) Section staff used GIP to manage medical supply inventory. However, they were not fully using GIP features to meet the inventory goal of 30 days or less. A physical inventory of supplies had never been performed, and the values of some supply items were overstated in GIP. As of April 2003, the SPD inventory consisted of 3,036 items with a stated value of $780,160. To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 medical supply items and found 2 deficiencies.

First, the GIP value of stock was overstated. GIP showed the 20 stock items reviewed were valued at about $60,925. The actual value of this stock was $41,027, which was only 67.3 percent of the reported GIP value ($41,027 ÷ $60,925). Applying the 67.3 percent figure to the $780,160 value for the entire medical supply stock shown in GIP would yield an actual value of $525,048.

Second, stock on hand exceeded 30 days. Fifteen of the 20 sampled items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 32 days to 6 years of supply. The estimated value of stock exceeding 30 days for the 15 items was $27,488, or 67.0 percent of the $41,027 total value for the 20 items. The excess stock and inaccuracies in GIP occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-day standard. Because the GIP data was inaccurate, we could not precisely determine the value of stock on hand or the value of excess stock for the entire inventory. However, by applying the 67.0 percent of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock is about $351,782 (67.0 percent x $525,048 estimated actual value of stock). SPD management agreed that in order to improve accuracy of GIP, inventory should be reduced and staff should monitor supply usage and adjust stock levels accordingly.

Prosthetic Supplies. The Prosthetic Treatment Center (PTC) used both GIP and VA's Prosthetics Inventory Package (PIP) automated system to control inventory. However, prosthetic inventory exceeded the 30-day standard. The PTC maintained a supply inventory of 3,063 line items valued at $253,115. To evaluate inventory levels, we reviewed a judgment sample of 20 items (PIP value = $151,899, which was 60.0 percent of the total inventory value). We found that the

stock values shown in PIP were generally accurate. However, 15 of the 20 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 50 days to 8 years of supply. For the 15 items, the estimated value of stock exceeding 30 days was $122,856, or 80.9 percent of the total inventory value for the 20 items. The excess prosthetic inventory occurred primarily because the PTC staff were not properly monitoring PIP and GIP features and were not adjusting stock levels to reflect actual usage rates. By applying the 80.9 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of excess stock was about $204,770 (80.9 percent x $253,115 actual PIP value of stock).

Engineering Supplies. The Engineering Section used GIP to manage 4 general categories of engineering supplies (about 54 line items). However, most engineering supplies were not controlled with GIP. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgment sample of 10 supply items, 3 of which were controlled with GIP. For the 7 of 10 items that were not controlled with GIP, we asked Engineering Section staff to estimate usage rates. Stock on hand exceeded the 30-day goal for 5 of the 10 items, with inventory levels ranging from 60 days to 6 years of supply.

Excess engineering supply inventory occurred because the Engineering Section did not use GIP or other inventory controls for most engineering supplies. In addition, there was minimal coordination between the Engineering Section and the Acquisitions and Materiel Management Section (A&MMS) to develop plans for phasing in GIP for all engineering supply items. Without sufficient inventory records, we could not estimate the value of all engineering supplies or the amount of inventory that exceeded current needs. However, the Chief of the Engineering Section acknowledged the need to reduce the inventory and to develop a comprehensive plan for controlling supplies with GIP. During our review, he prepared an "Engineering Rollout Plan" to provide an estimated timeline for bringing various items into GIP.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director requires: (a) the SPD Section to monitor supply usage rates, reduce excess medical supplies, and improve the accuracy of GIP data; (b) the PTC to reduce excess inventory and monitor supply usage in PIP and GIP; and (c) the Engineering Section to reduce excess inventory and work with A&MMS to implement GIP phase-in plans for engineering supplies.

The VISN Director and VAMC Director agreed and reported that plans had been developed to monitor usage rates and reduce excess medical supply inventory by September 30, 2003. As of May 2003, plans to monitor prosthetics supply use and to reduce excess inventory had been implemented. In addition, the Engineering Section, in conjunction with A&MMS, formulated a rollout plan to implement GIP for engineering supplies. The target date for full implementation is June 1, 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Management of Violent Patients Program – Systems to Alert Employees Should Be Improved

Condition Needing Improvement. VAMC management had developed an effective program for preventing and managing patient violence. However, the program could be strengthened by posting alerts about potentially violent patients in the VAMC's Computerized Patient Record System (CPRS) and the Veterans Health Information Systems and Technology Architecture (VISTA).

Posting alerts in CPRS and VISTA electronic records would notify employees about patients with violent histories. We reviewed CPRS and VISTA records for 10 patients who had documented incidents of violence. None of the records contained alerts. To ensure patient and employee safety, all VAMC employees need to know when a patient with a potential for physical violence presents for treatment.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director implements procedures to post CPRS and VISTA alerts about potentially violent patients. The VISN Director and VAMC Director agreed and reported that plans had been developed to review each incident of patient violence to determine if there is potential for future violent behavior by the veteran and to post alerts in CPRS and VISTA as appropriate. The target date for full implementation of these plans is July 1, 2003. The improvement actions are acceptable, and we will follow up on the completion of the planned actions.

Laboratory Security – Access Should Be Restricted to Authorized Personnel

Conditions Needing Improvement. Physical security deficiencies in the main clinical laboratory area needed to be corrected. VHA policy requires that access to BioSafety Level III (BSL-III) laboratories be limited to authorized individuals and that a record of persons entering the area be maintained. Three entrances to the medical center wing housing the main clinical laboratory and two BSL-III clinical laboratories were unlocked, resulting in unrestricted access to the area. None of the laboratories kept logs to record entries by visitors, maintenance workers, or others needing one-time or occasional entry. In addition, within the main laboratory, an incubator containing Mycobacterium tuberculosis (TB) cultures had no lock to prevent unauthorized access.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director implements plans to: (a) restrict access to the clinical laboratory area and (b) lock the incubator containing TB cultures. The VISN Director and VAMC Director agreed and reported that plans had been developed to restrict access to the laboratory area by July 1, 2003. In addition, as of June 2003, the incubator containing TB cultures had been fitted with a padlock. The improvement actions are acceptable, and we will follow up on the completion of the planned actions.

Medical Care Collections Fund – Coding and Billing Errors Should Be Corrected

Conditions Needing Improvement. VAMC staff needed to ensure that only bills with correct diagnostic and procedure codes were sent to insurers for collection. As of February 2003, the VAMC had 58,141 insurance accounts receivable with a total value of $16.1 million. Of these receivables, 25,789 valued at $5.8 million (36.0 percent of the total value) were more than 90 days old. To evaluate collection potential, we reviewed a judgment sample of 25 receivables (value = $1.2 million). Based on our review and discussions with the Patient Accounts Manager and the Coding Unit Supervisor, we concluded that Patient Accounts staff had vigorously pursued the receivables. However, three of the bills (value = $196,816) contained coding errors.

Two inpatient bills (from March and May 2002) and one outpatient bill (from July 2002) had codes assigned with lower reimbursement values than supported by the medical record documentation. As a result, these bills were understated by $96,357. The amount of the outpatient bill was minimal, but the amounts for the inpatient bills were significant. The billing errors occurred because certified coders had not properly reviewed coding done by noncertified coders. To address concerns about accuracy, in October 2002 VAMC management changed coding practices so that only certified coders, who had received specialized training, coded inpatient episodes of care. Although this change reduced coding errors on bills after October 2002, there may have been errors on other bills sent before then.

The Patient Accounts Manager agreed to submit amended bills for the three erroneous bills. The VAMC collection rate for insurance receivables is about 20.6 percent. Therefore, the VAMC should recover about $19,850 ($96,357 underbilled x 20.6 percent collection rate) on the reissued bills. In addition, VAMC management should require Patient Accounts staff to review other large inpatient bills coded before October 2002 and to submit amended bills as appropriate.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VAMC Director implements procedures to: (a) rebill the insurance companies for the three understated bills identified by our review and (b) review other outstanding inpatient bills to determine if there is further collection potential and submit amended bills as appropriate. The VISN Director and VAMC Director agreed and reported that as of June 2003, the erroneous bills had been rebilled and that plans had been developed to review and correct other bills coded before October 2002. The target date for full implementation of these plans is September 30, 2003. The improvement actions are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Cardholders Should Have Proper Warrant Authorities

Condition Needing Improvement. VAMC management and the Purchase Card Coordinator (PCC) needed to ensure that six employees with Government Purchase Cards had proper warrant authorities. VHA policy requires that purchase cards be used for all purchases under the micro-purchase level of $2,500 and, where practicable, for all purchases up to the simplified acquisition threshold of $100,000. For purchases up to the $2,500 level, cardholders are required to

complete basic Government Purchase Card training but do not need to have warrant authorities. However, for purchases over this level and up to the $100,000 threshold, cardholders must receive additional procurement training and must be issued proper warrants.

We reviewed purchase card use for the 3-month period December 2002–February 2003 and found that six cardholders did not have proper warrants for purchases over the $2,500 micro-purchase limit. One of the six cardholders regularly purchased prosthetic items costing more than $25,000, and two other cardholders routinely made purchases larger than $2,500 and up to $24,000. Without warrants with specified limitations, these cardholders did not have proper authority to commit the Government for these large purchases.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director takes action to provide proper training and warrants to cardholders who make purchases up to the simplified acquisition threshold. The VISN Director and VAMC Director agreed and reported that by July 1, 2003, the PCC and A&MMS will identify cardholders needing warrants and provide appropriate training. The improvement actions are acceptable, and we consider the issues resolved.

Equipment Accountability – Equipment Inventory Lists Should Be Corrected and Updated

Condition Needing Improvement. The VAMC needed to improve procedures for correcting and updating equipment inventory lists (EILs) of nonexpendable equipment (items costing more than $5,000 with an expected useful life of more than 2 years). VAMC policy requires that EIL inventories be done annually. A&MMS staff are responsible for coordinating EIL inventories, and all VAMC services are required to perform inventories of assigned equipment and to update EILs when equipment is moved or excessed.

As of February 2003, the VAMC had 108 EILs (equipment value = $79.8 million). To determine if equipment was properly accounted for, we reviewed a judgment sample of 25 items assigned to 5 EILs (combined value of 25 items = $1.1 million). For 16 of the 25 items (64 percent), the EIL entries were inaccurate or incomplete. Six of the 16 items had inaccurate or missing serial numbers or barcodes. Five items were not in the locations listed on the EILs. The remaining five equipment items could not be located during our review (value = $259,668).

Inaccurate and incomplete inventories occurred because VAMC staff did not correct EIL data input errors or consistently update the EILs when equipment was moved or excessed. When EIL information is inaccurate or incomplete, it is difficult to properly account for and safeguard equipment.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director implements procedures to correct and update inaccurate and incomplete EILs. The VISN Director and VAMC Director agreed and reported that as of June 2003, all of the EILs had been reviewed, retraining of Inventory Management Specialists and Supply Technicians had been accomplished, and inventory notification procedures had been revised to improve the

accuracy and completeness of EILs. The improvement actions are acceptable, and we consider the issues resolved.

Service Contracts – Contract Monitoring Should Be Improved

Condition Needing Improvement. VAMC management needed to ensure that only designated contracting officer's technical representatives (COTRs) certified contractor invoices. For each service contract, the contracting officer designates a COTR. The COTR is responsible for monitoring the contractor's performance and ensuring that services are provided in accordance with contract terms. This responsibility includes reviewing contractor invoices and certifying that the charges accurately reflect the work completed. According to VAMC policy, COTRs may not redelegate their authority to another person.

To determine if VAMC contract administration procedures were effective, we reviewed 10 service contracts (estimated combined annual costs = $12.1 million). For 3 of the 10 contracts, VAMC staff other than the designated COTRs had certified the contractor invoices, and FRS staff had issued payment based on these certifications. For one of the three contracts, payment had been certified for a charge that was not allowed under the contract. These problems occurred because COTRs were not properly trained on their responsibilities and FRS staff did not verify that only designated COTRs had certified invoices before issuing payments to contractors.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director takes action to provide refresher training to COTRs regarding their responsibilities and to FRS staff regarding the need to verify that only designated COTRs have certified contractor invoices. The VISN Director and VAMC Director agreed and reported that as of June 2003, procedures had been implemented to provide refresher training and to ensure that FRS staff only pay invoices that have been properly certified by designated COTRs. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – VISTA Access for Former Employees Should Be Terminated

Condition Needing Improvement. We reviewed VAMC information technology security to determine if controls were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for computer rooms and equipment was adequate, critical data was regularly backed up and properly stored off-site, and annual computer security awareness training was provided as required. However, VISTA access had not been promptly terminated for two former employees.

We reviewed the need for VISTA access for a sample of 60 VISTA users including VAMC employees, contract employees, residents, volunteers, and remote site VA employees (such as VISN and National Cemetery System employees). We found that access should have been terminated for two remote site users who were no longer employed by VA. When we brought

these cases to their attention, Information Management Service Line (IMSL) staff immediately terminated VISTA access for these former employees. The Information Security Officer stated that he would re-emphasize to the remote site service chiefs the need to inform the IMSL when employees no longer need access to VISTA.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director requires that VISTA access is terminated promptly for all individuals who do not have a continued need for access. The VISN Director and VAMC Director agreed and reported that as of June 2003, procedures had been implemented to identify remote site users who no longer require VISTA access or are no longer employed by VA. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
1	Better use of funds by reducing excess medical and prosthetics supply inventory.	$556,552
N/A	Better use of funds through collection of amended MCCF bills.	$19,850
	Total	$576,402

Appendix B

VISN 16 Director Comments

Department of Veterans Affairs

Memorandum

Date: May 30, 2003

From: Network Director, South Central VA Health Care Network (10N/16)

Subj: Response/Action Plan to Office of Inspector General Combined Assessment Program Program Report (Project No. 2003-01379-R8-0079)

To: Assistant Inspector General for Auditing

1. I appreciate the opportunity to review the Office of Inspector General Combined Assessment Program draft report of the recent visit to the Houston VA Medical Center in April 2003. I have reviewed the comments and the implementation plan submitted by the Medical Center Director and concur with his remarks.

2. Please extend my appreciation to the audit team for their thorough review, evaluation, and report of their visit to the Houston VA Medical Center. Thank you.

(Original signed by:)
Robert Lynch, M.D.

Appendix C

Houston VA Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: May 30, 2003

From: Medical Center Director, VAMC Houston, TX (580/00)

Subj: Response/Action Plan to Office of Inspector General Combined Assessment Program Report (Project No. 2003-01379-R8-0079)

To: Assistant Inspector General for Auditing (52)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program draft report of the Houston VA Medical Center. Comments and the implementation plan are included with transmittal of this memorandum.

2. I am pleased with the outcome of the review and the affirmation that the Houston VA Medical Center provides high quality health care to our Nation's veterans. Also significant are the high levels of patient and employee satisfaction that were noted by the audit team. Please express my appreciation to the auditors and support staff who conducted the review during the week of April 21, 2003 for their professionalism and efforts to assist in improving the medical center's operations and controls.

3. Should you have any questions regarding the comments or implementation plan, do not hesitate to contact me. Thank you.

(Original signed by:)
EDGAR L. TUCKER

Appendix C

HOUSTON VA MEDICAL CENTER
Comments and Implementation Plan

1. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the VAMC Director requires: (a) the SPD Section to monitor supply usage rates, reduce excess medical supplies, and improve the accuracy of GIP data; (b) the PTC to reduce excess inventory and monitor supply usage in PIP and GIP; and (c) the Engineering Section to reduce excess inventory and work with A&MMS to implement GIP phase-in plans for engineering supplies.

a. Supply, Processing, and Distribution (SPD) Section:

Concur with recommended improvement actions:

With regard to actions to adjust stock levels, as of May 27, 2003, 260 inventory items not used within a year have been offered as excess to other federal facilities to reduce inventory levels. This practice has been in effect and will be continued quarterly. Inventory deemed non-usable due to condition has been removed. Items on "Kill When Zero" (KWZ) status for non-usage have been discontinued. During the second quarter of Fiscal Year 2003 (FY03), review of use and adjustment of inventory levels have been completed on approximately 75 percent of inventory items, beginning in areas with larger numbers of low-volume items (e.g. operating room). Reorder points of zero will be considered where necessary and appropriate. Users will be asked to discontinue low-use items, as possible. This will be continued until all inventory items in SPD have been reviewed. Low-volume usage items will be issued to secondary supply sites/units, and maintained there, instead of SPD, as appropriate. Low-usage items will also be flagged for monitoring to reduce order history, with users given the option of SPD purchase versus user purchase with storage documentation.

Target Date: September 30, 2003

In an effort to improve monitoring of supply usage rates, several actions are being taken. The "Days of Stock on Hand" report will be monitored weekly, and reviewed bi-weekly in the standing meeting with the Associate Director, along with financial reports. Random audits by supervisors of a minimum of 10 items per inventory technician will be accomplished to monitor appropriateness of inventory management. Inventory management staff will be provided additional Generic Inventory Package (GIP) training. Physical inventory will be accomplished for the cardiac catheterization supply inventory (completed May 27, 2003), sterile instrument supply inventory to include new labels (target date: June 9, 2003), special funding supply inventory including data input (target date: July 2, 2003), and sutures/endo mechanics supply inventory to include data input (target date: July 18, 2003). In addition, inventory of all SPD line items will be reviewed and adjusted to include item level, re-order point, and emergency level re-order (target date: July 31, 2003).

Appendix C

Target Date: July 31, 2003

An annual physical inventory is planned for August 2003 per newly released (March 19, 2003) VHA Handbook 1761.2 (VHA Inventory Management). Previous handbook did not require annual physical inventory. SPD supply inventory to be completed in three groups on August 10, 24, and 30, with the area closed on each of these Saturdays. Data entry to be completed the day following each group inventory.

Target Date: August 31, 2003

b. Prosthetic Treatment Center (PTC):

Concur with recommended improvement actions:

In FY02 the PTC established a monitoring program which consists of team members from both disciplines, durable medical equipment (DME) and orthotic/prosthetic lab, and includes individuals from the Acquisition and Materiel Management Section (A&MMS). The team conducts reviews of inventory levels on a weekly basis. The team uses the Prosthetics Inventory Package (PIP) and the GIP inventory reports to determine which items are inactive or have low turnover rates. Any items identified as access are offered to other facilities. To date, the PTC has excessed $243,109 worth of inventory. Efforts will continue so that excessive items can be identified and reduced as appropriate. Reorder points are being set to zero where necessary and low-usage items are not replaced once depleted or excessed. Regarding adjustment of stock levels, a weekly inventory check has been implemented. The PTC is in the process of establishing a suspense method that should decrease the turnaround time for receiving reports. This will allow for update of the inventory levels in a timelier manner. In May 2003, a new reporting method was implemented which calculates the quantity of items that should be on hand based on the number of items provided for any given timeframe. This will also be beneficial in determining the appropriate number of items to purchase.

Completed.

c. Engineering Section:

Concur with recommended improvement actions:

The Engineering Section has formulated, with A&MMS, a roll-out plan for GIP implementation. This plan will take approximately 12 months and will include the plumbing shop, paint shop, carpenter shop, boiler plan, grounds maintenance shop, and the biomedical shop.

Target Date: June 1, 2004

Appendix C

2. Management of Violent Patients Program – Systems to Alert Employees Should Be Improved

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the VAMC Director implements procedures to post CPRS and VISTA alerts about potentially violent patients.

Concur with recommended improvement actions:

Each Code Green report from the Behavioral Response Team will be reviewed by a team led by a mental health practitioner to determine if the factors surrounding the Code Green incident appear to indicate a potential for future violent behavior by the veteran. If the team believes that the demonstrated behavior may reoccur under certain circumstances, the team leader will post an alert in the VA Medical Center's Computerized Patient Record System (CPRS) and the Veterans Health Information Systems and Technology Architecture (VISTA) describing the veteran's potential for future violent behavior and a proposed intervention. This clinical judgment will be based upon the veteran's clinical background, including a full, formal five Axis DSM IV diagnosis, and a review of contributing factors leading to the Code Green incident. The decision will not be based solely on the veteran's current mental status.

Target Date: July 1, 2003

3. Laboratory Security – Access Should Be Restricted to Authorized Personnel

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the VAMC Director implements plans to: (a) restrict access to the clinical laboratory area and (b) lock the incubator containing TB cultures.

a. Restrict Access:

Concur with recommended improvement actions:

Measures to improve restricted access to the laboratory will be initiated following a thorough review of both architectural and procedural elements of the laboratory area and operations. Employee education has occurred, and will be ongoing, regarding visitors and access issues.

Target Date: July 1, 2003

b. Incubator Security:

Concur with recommended improvement actions:

The mycobacterial (TB) incubator has been fitted with a padlock.

Completed.

Appendix C

4. Medical Care Collections Fund – Coding and Billing Errors Should Be Corrected

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the VAMC Director implements procedures to: (a) rebill the insurance companies for the three understated bills identified by our review and (b) review other outstanding inpatient bills to determine if there is further collection potential and submit amended bills as appropriate.

a. Rebill the Insurance Companies

Concur with suggested improvement actions:

Medical Care Collection Fund (MCCF) staff has completed rebilling of two of the three understated bills identified in the sample. Bill K2579YU in the amount of $56,666.70 was identified as being understated, the coding errors were corrected, and the services rebilled on K306ZWR totaling $126,461.17. Bill K257W38 in the amount of $40,076.72 was identified as being understated, the coding errors were corrected, and the services rebilled on K306ZX7 totaling $77,279.44. Bill K6D2433 was also identified as being understated; however, the dates of service on this claim were prior to the reasonable and customary billing rates. Therefore, since changing the coding information would not affect the charges of the claim, the claim was not rebilled. Due to Health Information Management Section (HIMS) correcting the understating of these two claims, MCCF was able to generate bills for an additional $106,997.19.

Completed.

b. Review Other Outstanding Inpatient Bills

Concur with suggested improvement actions:

HIMS is currently reviewing all billed admissions between October 1, 2001 and September 30, 2002 to identify and correct any additional understating errors. HIMS will notify MCCF staff of any admissions that need to be re-billed.

Target Date: September 30, 2003.

5. Government Purchase Card Program – Cardholders Should Have Proper Warrant Authorities

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the VAMC Director takes action to provide proper training and warrants to cardholders who make purchases up to the simplified acquisition threshold.

Concur with suggested improvement actions:

Appendix C

In conjunction with the Purchase Card Program Coordinator, A&MMS will complete a review of all purchase cardholders to determine individuals needing warrants over the micropurchase threshold. For the identified individuals, A&MMS will provide training to allow those identified cardholders to make purchases up to the appropriate level within the simplified acquisition threshold. Upon successful completion of training, warrants will be issued by the Houston VA Medical Center Head of Contracting Activity (Manager, A&MMS). A&MMS, in conjunction with the Purchase Card Program Coordinator, has established a report indicating dollar amounts of individual orders placed by cardholders for review, as needed.

Target Date: July 1, 2003

6. Equipment Accountability – Equipment Inventory Lists Should Be Corrected and Updated

Suggested Improvement Action 3. We suggest that the VISN Director ensure that the VAMC Director implements procedures to correct and update inaccurate and incomplete EILs.

Concur with suggested improvement actions:

A number of actions have been taken since the review. Procedures have been established for correcting and updating inaccurate and incomplete Equipment Inventory Lists (EILs). The EILs have been reviewed and have been found to be adequate. Re-training has been accomplished with all Inventory Management Specialists and Supply Technicians responsible for inventories regarding the importance of following the established procedures. New barcode readers have been ordered and received. All Inventory Management Specialists and Supply Technicians responsible for inventories have been trained on use. The new barcode readers will electronically record and, when downloaded into inventory system, will automatically update and correct equipment status. Because A&MMS is accountable for equipment inventories and Care/Service Line Executives are responsible for equipment inventories, the notification of annual physical inventory memorandum issued by the Manager, A&MMS, has been revised to include special instructions regarding proper processing/handling of equipment that cannot be located, equipment to be placed in excess, and/or equipment to be taken out of service.

Completed.

7. Service Contracts – Contract Monitoring Should Be Improved

Suggested Improvement Action 4. We suggest that the VISN Director ensure that the VAMC Director takes action to provide refresher training to COTRs regarding their responsibilities and to FRS staff regarding the need to verify that only designated COTRs have certified contractor invoices.

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Concur with suggested improvement actions:

A list of designated Contracting Officer's Technical Representative (COTR's) by individual station contract that are to be paid via certified invoice has been developed and sent to Financial Resources Management Section (FRMS) of the Business Office Service Line, who, in turn, will verify that the signature authorizing payment of the certified invoice is that of the designated COTR. Before authorizing payment of a certified invoice, FRMS will verify that a designated COTR has signed the invoice certifying the services/products have been received, either by physically checking the Fiscal copy of the station contract or by checking the COTR listing. In addition, the Contracting Officer's Handbook has been placed on the Houston VA Medical Center's "P" drive on the computer network for employees to access for COTR training. The COTR designation memo includes written instructions specifically outlining responsibilities of the COTR.

Completed.

8. Information Technology Security – Security Deficiencies Should Be Corrected

Suggested Improvement Action 5. We suggest that the VISN Director ensure that the VAMC Director requires that VISTA access is deactivated promptly for all individuals who do not have a continued need for access.

Concur with suggested improvement actions:

A process has been developed and implemented for quarterly reports to be sent to all Care/Service Line Executives and responsible persons from remote sites with a roster of employees with VISTA access. The roster is to be returned to the Information Security Officer identifying employees on the list who are no longer employed or requiring VISTA access.

Completed.

Appendix D

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This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.