Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review
Hunter Holmes McGuire
VA Medical Center
Richmond, Virginia

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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:

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

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

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Executive Summary

Introduction. The Office of Inspector General conducted a Combined Assessment Program review of the Hunter Holmes McGuire VA Medical Center (HHMMC) in Richmond, Virginia, during the week of October 16-20, 2000. The purpose of the review was to evaluate selected medical center operations, focusing on patient care and quality management, financial and administrative management controls, and fraud prevention.

The 703-bed HHMMC offers primary, secondary, and tertiary diagnostic and therapeutic health services in medicine, surgery, neurology, rehabilitation medicine, intermediate care, acute and sustaining spinal cord injury, skilled nursing home care, and palliative care. It also provides primary and secondary levels of psychiatric care. The HHMMC's Fiscal Year (FY) 2000 budget was $181 million and the staffing level was about 1,800 full-time equivalent employees. In FY 2000 the HHMMC treated over 9,400 inpatients and provided about 290,000 outpatient visits.

Patient Care and Quality Management. HHMMC managers' attitudes and actions supported quality management (QM) and performance improvement. The HHMMC had a comprehensive, well-organized, and proactive QM Program that effectively coordinated patient care activities and properly monitored the quality of care. However, some issues related to patient care oversight needed management attention.

We suggested that the HHMMC Director address patient care, QM, and administrative issues as follows: (a) improve provider documentation and coding of outpatient clinic visits; (b) enhance provider credentialing and privileging activities; (c) ensure timely access to the Pain Clinic; and (d) fully implement VHA's "*Pain as the 5th Vital Sign"* initiative. We also recommended improving the Contract Nursing Home (CNH) Program by: (a) assuring compliance with CNH monthly visitation and annual inspection requirements; (b) pursuing alternatives to reduce CNH contract costs; (c) revising CNH policy to be consistent with VA directives; and (d) designating a Contracting Officer's Technical Representative as required.

Financial and Administrative Management. The HHMMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we suggested that the Director: (a) strengthen internal controls over the purchase card program; (b) more closely monitor the Agent Cashier; (c) enhance automated information system security; and (d) decrease billing lag times for Medical Care Collection Fund recoveries. We also recommended that the Director ensure that inventory levels be aggressively monitored toward the goal of eliminating unused stock and reducing inventory levels to 30 days.

Fraud Prevention. Managers fully supported fraud prevention efforts. During the review we provided fraud and integrity awareness training for 132 HHMMC employees.

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

(Original signed by)

RICHARD J. GRIFFIN
Inspector General

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Introduction

Hunter Holmes McGuire VA Medical Center

The Hunter Holmes McGuire VA Medical Center (HHMMC) in Richmond, Virginia, provides primary, secondary, and tertiary diagnostic and therapeutic health services in medicine, surgery, neurology, rehabilitation medicine, intermediate care, acute and sustaining spinal cord injury, skilled nursing home care, and palliative care. The HHMMC is one of eight medical centers in Veterans Integrated Service Network (VISN) 6 – the Mid-Atlantic Health Care Network.

Affiliations and Programs. The HHMMC is affiliated with the Medical College of Virginia and 31 other colleges and universities in Allied Health Science Programs such as nursing, social work, pharmacy, dietetics, rehabilitation, computer sciences, dental, clinical pastoral education, health administration, podiatry, and speech pathology. The facility offers a broad range of diagnostic and therapeutic services including a dialysis unit, magnetic resonance imaging, cardiac catheterization, mammography, radiation therapy, electrophysiology, and lithotripsy.

The HHMMC acts as a tertiary care referral center for subspecialty treatment, traumatic brain injury, spinal cord disorders, open-heart surgery, oncology, and vascular diseases. In addition, the HHMMC is a national referral center for heart, lung, and liver transplantation. Other special programs include a comprehensive cancer center, prosthetic treatment center, regional audiology center, hospice unit, and geriatric evaluation unit.

Resources. The Fiscal Year (FY) 2000 budget was $181 million. Staffing totaled about 1,800 full-time equivalent employees, including 111 physicians. The HHMMC had 269 medical, 114 surgical, 120 spinal cord injury, 80 psychiatric, and 120 nursing home beds authorized at the beginning of FY 2001.

Workload. In FY 2000, HHMMC clinicians provided about 103,000 inpatient days of care to about 9,300 medical, surgical, spinal cord injury, and psychiatric patients and about 26,000 inpatient days of care to about 130 nursing home patients. The average daily census of inpatients was 127 medical, 32 surgical, 54 spinal cord injury, 15 psychiatric, and 71 nursing home patients. The outpatient workload was about 290,000 visits.

Objectives and Scope of the Combined Assessment Program

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

Patient Care and Quality Management Review. We reviewed selected clinical activities with the objective of evaluating the effectiveness and appropriateness of patient care and quality management (QM). The QM Program is comprised of a set of integrated processes that are designed to monitor and improve the quality and safety of patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and ensuring employee competence.

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

- Quality Management Program
- Contract Nursing Home Program
- Narcotics Use in Mental Health
- Pain Management in Acute Care
- Physician Credentialing and Privileging
- Outpatient Documentation and Coding

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

- Agent Cashier Operations
- Pharmacy Service Security
- Enhanced Use Lease Agreements
- Community Nursing Home Contracts
- Automated Information System Security
- Medical Care Collection Fund
- Maintenance and Housekeeping
- Inventory Management
- Purchase Card Program
- Accounts Receivable
- Unliquidated Obligations
- Physician Time and Attendance
- Telephone Security

Fraud Prevention. We conducted 3 fraud and integrity awareness briefings for 132 HHMMC employees. The presentations included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and a question and answer session.

Scope of Review. The CAP review generally covered VAMC operations from January 1999 through October 2000. The review was done in accordance with Standard Operating Procedures for the VA Office of Inspector General CAP reviews.

Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

We concluded that patient care and QM programs were comprehensive and generally well managed, and that clinical activities were operating effectively. In general, employees and patients stated that the facility provided good patient care. We found the physical environment to be clean, bright, well maintained, and easy to navigate.

The QM Program Was Comprehensive and Well Organized. The HHMMC's QM Program included utilization review, performance improvement, risk management, and administrative investigations. Areas that we inspected included: administrative investigations; root cause analyses/focused reviews; tracking of external review recommendations; peer reviews; and tort claims. We found that QM employees were proactive in identifying and targeting high volume, high cost, and high vulnerability areas for QM review. HHMMC managers developed an oversight committee - Quality Assessment and Improvement Committee - which monitored medical center process action and improvement teams, clinical subcommittees, and QM activities. Overall, we concluded that the QM Program was a strong and integral component of medical center operations.

Psychiatrists Properly Controlled Narcotic Prescriptions to Mental Health Patients. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require that healthcare organizations have controls in place to ensure that the rationale for prescribing long-term (maintenance) narcotics is adequately documented in the medical records. Because the mental health population is often at considerable risk for addiction or other undesirable side effects, we reviewed prescription-writing practices of attending psychiatrists. Our sample of medical records included those patients in Mental Health with pre-selected specified primary treatment diagnoses, and who received two or more prescriptions for Oxycodone (Percocet®) or Codeine (Tylenol ®-III) from an attending psychiatrist within the past 12 months.

We reviewed the medical records of the five patients meeting all elements of the criteria and found that in each case, there was a documented treatment plan addressing the need for pain medication. Furthermore, there was documentation that alternative therapies had been considered or attempted prior to prescribing or renewing narcotic medications. All psychiatrists interviewed reported that they do not routinely prescribe narcotics, but refer any patient requiring long-term pain management to a primary care provider or the Pain Clinic. Our medical record review confirmed this practice.

Opportunities for Improvement in Various Patient Care, Quality Management, and Administrative Functions

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

Providers Should Improve Outpatient Documentation and Coding. The Veterans Health Administration (VHA) has been increasing its efforts to meet Medicare billing compliance regulations while also meeting JCAHO standards for appropriate documentation. Previous VHA studies have shown recurring problems with improper billing and adequacy of supporting documentation.

We reviewed 40 medical records to determine HHMMC clinicians' compliance with coding and billing standards. We selected medical records based on predefined outpatient encounter codes. The selected codes encompassed routine to complex care. Our documentation review was based on criteria outlined in Health Care Financing Administration (HCFA) guidelines. We found that documentation (usually progress notes) supported the assigned encounter codes in 19 of 40 (47.5%) medical records. Of the 21 encounters that were incorrectly coded, 19 were up-coded (reflecting a higher complexity of service than actually occurred), and 2 were down-coded (reflecting a lesser complexity of service than actually occurred).

Senior managers were aware of the discrepancies in the coding and billing process and had instituted a system whereby individual providers were given data showing their compliance with coding guidelines. Providers were given instructions on coding and documentation standards. Managers should enhance efforts to improve provider compliance with coding and documentation standards.

Managers Should Address Credentialing and Privileging (CP) Concerns. VHA policy and JCAHO standards define the credentialing, privileging, reappraisal, and reprivileging processes for healthcare practitioners in VA settings. We reviewed HHMMC's CP policies and procedures to determine if the credentials of physicians treating VA patients had been properly evaluated and approved. We reviewed 10 CP files including a mix of attending physicians. In general, we found HHMMC's CP process to be adequate; however, we noted several issues requiring increased medical center managers' attention:

- Managers should assure that CP actions and the rationale for those actions are recorded in minutes of the meetings in which those actions are taken. Minutes reflected only final actions taken, with no discussion, and no explanation of the rationale for conclusions.

- The ongoing second level review of all CP files should be documented and aggregated on a recurring basis. According to program officials, there was a second level review on all files, but there was no documentation or aggregation of data.

- Licensure verification should be completed for all licenses, including lapsed or expired licenses. When physicians relocate to and become licensed in a new state, they may allow their licenses to lapse in the previous state. It is also possible that the physicians lost their licenses for cause. Documentation of the rationale for lapsed licenses should be obtained from the practitioner, verified with the relevant state licensing board, and retained in the CP file. We found that CP officials had not reviewed one Canadian license and two lapsed licenses.

Managers Should Address Pain Clinic Waiting Times. At the time of our visit in October 2000, the next available appointment in the Pain Clinic could not be scheduled until September 2001, and there were more than 325 consultation requests pending action. This clinic has one full-time physician. A nurse practitioner was recently hired but had not entered on duty at the time of our visit. Medical center managers were aware of the delays in the Pain Clinic and indicated that they were taking steps to increase staffing, implement an interdisciplinary program model, and use contract services to decrease delays. Medical center managers should ensure that actions taken to improve the Pain Clinic waiting times are effective.

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

We reviewed 11 patients' medical records, all of which contained initial pain assessments. However, only 8 of the 11 records (72.7 percent) included documentation of the pain score and location of the pain. Only 4 of 11 records (36.4 percent) had the intensity of the pain documented, 3 of 11 (27.3 percent) documented the character of the pain, and 5 of 11 (45.5 percent) contained the duration of the pain. The pain scores were recorded with vital signs in 6 of 11 records (54.5 percent), and the nursing care plans and the patient responses to pain management were documented in only 8 of 11 records (72.7 percent). Pain management was only documented as part of discharge planning in one medical record (9.1 percent). HHMMC's draft policy on Pain did not address discharge planning activities.

We reviewed 10 education records for current nursing employees to determine if pain management training had been provided. None of the nursing education records reflected pain management training. HHMMC's draft policy on Pain failed to address employee educational requirements.

Medical center managers should ensure that the pain management policy is finalized and that it addresses discharge planning and education of employees. Managers should refer to VHA's publication entitled "*Pain as the 5th Vital Sign"* for guidance on implementing these measures.

Recommendations for Addressing Patient Care Oversight, Quality Management, and Administrative Issues

During the review, we identified several issues related to the Contract Nursing Home (CNH) Program, and made recommendations for improvements.

Managers Should Improve Clinical and Administrative Aspects of the CNH Program. The HHMMC's CNH Program functioned under the auspices of the Geriatrics and Extended Care Service Line. In October 2000, there were 29 veterans placed in 14 CNHs. A social worker and a nurse were assigned half time to the program. We reviewed HHMMC's CNH Program to determine: (a) the existence of required management and clinical oversight functions; (b) whether contract reimbursement rates met, or were below, VA benchmarks; and (c) the existence of a local CNH policy and its compliance with VHA guidelines. We interviewed employees who were knowledgeable about the CNH Program, examined contract files, patient records, and the facility CNH policy. We also visited one of the contracted nursing homes. At that home, we interviewed two veterans receiving care under VA contract, the wife of a veteran, and the Nursing Home Administrator.

Oversight Functions - We found that, despite VHA guidelines that require monthly visitation to all veterans in contract nursing homes by a nurse or social worker, there was no documentation of consistent monthly visitation in any of the 10 records reviewed. VHA policy also requires that a VA nurse visit CNH patients at least once every 60 days (usually this is alternated with the social worker's visits). The HHMMC complied with this requirement in only four of nine (44.4 percent) applicable medical records reviewed. Documentation of annual physical examinations and the need for continued nursing home placement was located in all of the applicable (indefinite contract patients) medical records.

VHA guidelines require that all CNHs receive, at a minimum, an annual inspection conducted by a VA nurse and social worker. We evaluated five CNH contract files, none of which contained evidence of the required onsite inspection by VA personnel. This is because HHMMC followed VISN 6 policy on CNH inspections (based on anticipated changes in VHA guidelines) that allowed their inspection team members to review HCFA reports of CNH deficiencies and, if satisfactory, forgo an onsite inspection.

CNH Contract Rates – The HHMMC could reduce annual CNH costs by over $112,000 by negotiating CNH contracts at VA benchmark rates. According to the Director, the HHMMC still used the old contracting methodology of negotiating rates for only two levels of care - reduced physical functioning and basic care. However, patients were placed with care requirements ranging from minimal deficiencies to heavy rehabilitation.

To account for these patients and their significant costs for specialized care, waivers were granted to exceed the VA benchmark percentages. The Director agreed that this could have been avoided in some cases had the multiple level case-mix system been utilized, as would have been more appropriate. Under the case-mix system, CNH rates allowed by VA vary according to the level of care at which the patient is placed:

- Reduced Physical Functioning Group — Medicaid + 8 percent
- Basic Care Group — Medicaid + 15 percent
- Special or Complex Care — Medicaid + 26 percent
- Rehabilitation Group — Medicaid + 60 percent

The following table provides details on the actual rates paid for 22 patients in 8 CNHs compared to VA benchmark rates, and the opportunities for cost efficiencies.

Annual Cost Savings That Could Be Achieved by Contracting at VA Benchmark Rates

CNH	VA Care Group	VA Benchmark Rate	Rate Paid by VAMC	Percent Over VA Benchmark	Dollars Over VA Benchmark	Number Of VA Patients	Annual Cost Savings
1	Intermediate	$100.35	$108.18	8%	$7.83	1	$2,858
	Basic	$106.85	$101.59			1	
	Rehab	$148.67	$108.18			2	
2	Intermediate	$100.79	$125.56	25%	$24.77	1	$9,041
	Intermediate	$100.79	$168.31	67%	$67.52	1	$24,645
	Rehab	$149.32	$125.56			1	
3	Rehab	$149.32	$168.31	13%	$18.99	2	$13,863
	Basic	$98.59	$124.03	26%	$25.44	1	$9,286
	Rehab	$137.17	$124.03			1	
4	Basic	$92.22	$116.95	27%	$24.73	1	$9,026
	Rehab	$128.30	$168.31	31%	$40.01	1	$14,604
5	Rehab	$136.80	$168.31	23%	$31.51	1	$11,501
6	Basic	$109.96	$125.03	14%	$15.07	1	$5,501
	Complex	$120.48	$125.03	4%	$4.55	2	$3,322
	Rehab	$152.99	$125.03			1	
	Rehab	$152.99	$168.29	10%	$15.30	1	$5,584
7	Basic	$120.80	$110.50			1	
8	Basic	$113.18	$108.94			1	
	Special	$124.00	$131.71	6%	$7.71	1	$2,814
	Totals					**22**	**$112,044**

As shown by the above table, 12 of 22 (55 percent) CNH patients were placed at rates that exceeded VA benchmark rates by $4.55 (4 percent) to $67.52 (67 percent) per day (compared to the allowable rate for the Care Group at which the patient was placed). Rates did not appear to be based on VA benchmark rates or on the level of care required by the patient. For example:

- CNH 1- Paying $101.59 for basic care, and $108.18 for both reduced physical and rehabilitation care.

- CNH 2 - Paying $125.56 for one reduced physical and one rehabilitation patient, but paying $168.31 for another reduced physical and another rehabilitation patient.

- CNH 3 - Paying $124.03 for a basic care patient and a rehabilitation patient.

- CNH 6 - Paying $125.03 for one basic care patient, one complex care patient, and one rehabilitation patient, but paying $168.29 for the other rehabilitation patient (these four patients were all placed in this CNH within 30 days of each other).

There are 18 other Virginia nursing homes available to the HHMMC on a VA multi-state contract that meets VA benchmark rates. The HHMMC had no patients in any of these homes. CNH employees stated that these homes rarely had beds for VA patients. The HHMMC should not place any more veterans in the CNHs with costs over VA benchmarks, but should pursue alternatives such as placing veterans in the CNHs on the multi-state contract or other CNHs under contract, negotiating contracts with other CNHs at the benchmark rate, or placing veterans in the State Veterans Home in Roanoke, VA.

Policy Compliance - The facility's CNH policy was not in compliance with current VHA directives in several key areas. Specifically, HHMMC's CNH policy did not mandate monthly visitation to CNH veterans or include provisions for collection and analysis of performance improvement data from the CNH.

Contracting Officer's Technical Representative (COTR) - We also found that there was no COTR designated for this program as required. The CNH Coordinator had been functioning in this role in an informal capacity, but had declined to sign the designation papers as it was felt this would place additional demands on the Coordinator's already limited time.

Recommendation 1 - We recommend that the Medical Center Director take the following actions to strengthen the CNH program:

a. Assure compliance with CNH monthly visitation and annual inspection requirements.

b. Pursue alternatives to reduce CNH contract costs.

c. Revise CNH policy to be consistent with VA directives.

d. Designate a COTR as required.

Medical Center Director Comments

The Medical Center Director concurred with the finding and recommendations. Clinical staff will be made available to ensure that the nurse visits each patient monthly, and that each nursing home is inspected annually. COTR responsibilities will be assigned to the CNH Coordinator. To assure appropriate rates are paid for each patient according to their level of care needs, the pricing structure for new contracts has been changed to the multiple case-mix structure. These contracts will be negotiated within the allowable benchmark rates or contracts will not be offered. The CNH policy will be revised to be consistent with VA directives.

Office of Inspector General Comments

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

Financial and Administrative Management

Management Controls Were Generally Effective

HHMMC managers had established a positive internal control environment, administrative activities that we reviewed were generally operating satisfactorily, and management controls were generally effective. We found no internal control weaknesses in the activities discussed below.

Implementation of a Personal Identification Number (PIN) Telephone Security System Significantly Decreased Long Distance Telephone Costs. The facility implemented a PIN security system at the beginning of FY 1998. Long distance telephone costs were $98,800 for FY 1997. Implementation of the PIN system resulted in savings in long distance telephone services of over $39,000 in 1998, and achieved savings of about $50,000 in FY 2000.

Pharmacy Service Had Effective Security Measures. Employees conducted monthly unannounced inspections of all Schedule II-V controlled substances as required, inspectors received appropriate training, unusable controlled substances were disposed of timely, physical security requirements were met, and managers followed guidelines for appropriately assigning employees to inspection teams.

Appropriate Controls Were in Place for Time and Attendance of Part-time Physicians. We verified the attendance of a sample of 10 of 55 (18 percent) part-time physicians who were scheduled to be on-duty during our onsite review. We also determined from records and interviews with timekeepers and other staff that appropriate controls were in place to monitor the physicians' attendance.

Facility Maintenance and Housekeeping Met High Standards. Tours of clinical, administrative, and public access areas consistently showed the highest levels of facility maintenance and housekeeping practices, which reflected favorably on the hospital's image as a facility of choice.

Followup on Unliquidated Obligations Was Timely. Responsibility for HHMMC's accrued services payable and undelivered orders had been consolidated to the fiscal activity at VAMC Salem, VA. Management of these accounts by VAMC Salem appeared adequate in that the amount of unliquidated obligations with greater than 90 days of inactivity was not significant. Unliquidated obligations for accrued services payables did not exceed $55,000, and was about $70,000 for undelivered orders.

Service Contracts Were Effectively Managed. Controls over contracts for provision of oxygen services and wheelchair transportation services ensured effective contract administration. Our review of the $500,000 contract to provide home oxygen services to veterans showed that controls over this program prevented the duplication of visits and

unauthorized payments. Similarly, our review of the $405,000 contract for transportation of wheelchair patients showed that controls ensured that the contractor was providing the services according to the terms of the contract.

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

Suggestions for Management Attention

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

The Purchase Card Coordinator Should Strengthen Internal Control Procedures. From October 1999 through August 2000, cardholders processed about 18,500 purchase transactions totaling approximately $17.2 million. Managers ensured that regular program quality reviews and audits were conducted as required to ensure that items purchased under this decentralized procurement method were actually received, charges were for official purposes only, and bills were correctly paid. We noted three areas of the program with potential for improvement:

Terminated Accounts - VA policy requires the purchase card accounts of former employees to be closed. Local practice allowed the accounts of former employees to remain active for up to a year in order to facilitate any remaining purchase activity initiated prior to the employee leaving service. At the time of our review, there were eight accounts active for employees who had left employment up to 8 months earlier. Local practice should be revised to terminate former employee accounts immediately.

Approving Official Certifications - VA policy requires certification of reconciled purchase transactions within 14 days of receipt from the cardholder. Approving officials exceeded this period about 11 percent of the time during the first 11 months of FY 2000. Delinquent certifications ranged from 15 to 235 days. Although program managers regularly monitored this condition, they should pursue more aggressive means of reducing the percentage of late certifications. Managers agreed to develop a means of monitoring this condition more closely in the future.

Split Purchases - Purchase cardholders should not circumvent cardholder limitations by splitting their purchases into two or more transactions. Recurring management reviews identified potential split transactions by about 20 cardholders during FY 2000, but did not evidence sufficient corrective action to eliminate the practice. Managers agreed that they would take action to address this issue more aggressively in the future.

Managers Should More Closely Monitor the Agent Cashier. The $34,000 agent cashier cash advance was determined to be at the proper level to maintain adequate

funds for required transactions. However, two aspects of the agent cashier function required management attention:

- Unannounced audits were not adequately varied to ensure randomness.

- Responsibility and accountability for the advance was not effectively transferred to the alternate agent cashier for the required 2-week period each year.

Unannounced Audits - VA policy requires an unannounced audit of the agent cashier's advance at least every 90 days. The dates and times of unannounced audits should be varied to prevent the establishment of a pattern, and to ensure the element of surprise. We reviewed the results of audits performed from January 1, 1999, through October 2000. Audits were repeated from 63 to 84 days after the prior audit and were usually held on Wednesdays. To ensure surprise and provide more effective control, managers should perform audits on other days of the week than Wednesday. When we brought this issue to management's attention they agreed to correct this condition. The facility met other guidelines relating to separation of duties, security over the agent cashier area, and training for agent cashier audits.

Transfer of Responsibility - VA policy requires a complete transfer of responsibility and accountability for the cash advance from the agent cashier to the alternate agent cashier for a 2-week period each calendar year. The facility's practice had been to designate the alternate agent cashier as the primary cashier for such a period, but to allow the agent cashier to continue to conduct agent cashier duties. To enhance internal control, Fiscal Service managers should ensure that accountability and responsibility for the cash advance is completely transferred as required, and that the agent cashier has no primary cashier or alternate agent cashier responsibilities during the designated 2-week transfer period. Fiscal Service managers stated that they would comply with this requirement in the future.

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

Contingency and Recovery Plans - VAMCs are required to develop and implement information system contingency and recovery plans. The plans should be designed to reduce the impact of disruptions in services, provide critical interim processing support, and resume normal operations as soon as possible. The contingency plan effectively addressed most issues, but did not contain the following required elements:

- A listing of hardware and software configurations for the Local Area Network and Veterans Health Information System and Technology Architecture systems to facilitate the resumption of normal operations.

- The procedures for restricting access to disgruntled employees or employees in a reduction-in-force situation.

- The documentation of the results of readiness tests for resuming operations at an alternate site in the event of an emergency.

- A listing of the names, phone numbers, and duties assigned key personnel involved in disaster recovery so that they could be readily contacted.

AIS staff took immediate action to develop this information during our review, and program managers agreed to add this information to the plan.

Personal Computers - Virus control and copyright infringement was not monitored on a recurring basis for stand-alone personal computers. AIS staff had only intermittently monitored controls over personal computers in these security areas. They agreed that an on-going, documented program of audits could be accomplished by re-implementing previous monitors, developing other monitors, and enlisting the assistance of service program staff knowledgeable in AIS procedures.

Shorter Billing Lag Times Would Improve Medical Care Collection Fund (MCCF) Recoveries. The HHMMC collected over $8 million in FY 2000, exceeding the VISN's MCCF goals by 11 percent, and MCCF employees were performing the required follow-up on accounts that had been billed. However, our review of 10 inpatient and outpatient accounts valued at $800,000 showed that it took an average of 55 days to prepare a bill following receipt of care. Local studies showed the average billing lag time for FY 2000 as 51 days for inpatient care and 42 days for outpatient care. Although VA policy does not contain a standard for the number of allowable days to prepare the bill after receipt of care, many private sector hospitals and contract services average 9 days to issue bills to insurance carriers. Aggressively pursuing methods to reduce the billing lag time could further increase MCCF collections.

Recommendations for Improving Management Controls

Managers Should Improve Control Over Inventory Management. VA guidelines require the use of the Generic Inventory Package (GIP), an automated supply inventory system, to manage and control supply inventories. Inventories should not generally exceed a 30-day supply. HHMMC employees used GIP to manage the stock in four major inventory program areas: Supply & Distribution; Supply Processing and Distribution; Office Supplies; and Acquisitions & Material Management Warehouse Stock. These four areas contained about 2,250 line items of stock valued at $1.1 million.

Staff generally maintained accurate records of stock inventory in these programs and planned to expand use of GIP to include three other inventory programs: Pathology & Laboratory Medicine Service; Engineering Service; and the Cardiology Unit. However, managers did not use GIP to effectively manage inventory levels. Generally,

inventories should not exceed a 30-day supply, and even lower supply levels for additional economies can be achieved using present day electronic commerce initiatives.

GIP reports provided to us by HHMMC showed that inventory exceeded a 30-day supply for 1,815 line items valued at $819,000 (74 percent of $1.1 million). According to the VAMC Director, $597,870 (73 percent of $819,000) of the excess inventory resulted directly from efforts to clean up excess items stocked by services. Large numbers of items had already been identified as being in excess of their needs and, in many cases, no longer needed at all. Much of this stock had been in various storage areas throughout the VAMC for an extended period of time. Therefore, this stock was placed in the warehouse and entered into GIP until proper disposal could be arranged. Inventory managers agreed that the other 27 percent of the excess inventory, valued at $221,130, was too high because using services and warehouse managers were not closely monitoring actual use in relation to inventory levels.

Although various management reports were available under GIP to improve inventory control, employees were not familiar with some of them, or did not use them to consistently assess and manage inventory levels. Warehouse managers agreed that available management reports should be regularly used to identify input errors and address causes of excess inventory levels, and that they should eliminate unused stock and bring other existing stock to a 30-day level.

Recommendation 2 - We recommend that the VAMC Director ensure that inventories are aggressively monitored toward the goal of eliminating unused stock and reducing inventories to 30-day levels.

Medical Center Director Comments

The Medical Center Director concurred with the finding and recommendation. Inventory managers have already reduced the total value of the excess inventory, with the remaining overage to be eliminated within 90 days. GIP reports will be reviewed regularly, physical wall-to-wall inventories will be performed quarterly, and Inventory Managers have been counseled on the requirement to reduce excessive inventories and maintain acceptable levels.

Office of Inspector General Comments

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

Fraud and Integrity Awareness Briefings

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

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

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

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

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

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the Division are procurement

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

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is 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 charged.

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

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of Hunter Holmes McGuire VA Medical Center Richmond, Virginia

Project Number: 2000-02679-R3-0305

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Reduction in CNH Contract Rates	$112,000	
2	Reduction in Stock Inventory	$221,130	
Total		**$ 333,130**	

Medical Center Director Comments

DEPARTMENT OF VETERANS AFFAIRS
Hunter Holmes McGuire Medical Center
1201 Broad Rock Boulevard
Richmond VA 23249

January 10, 2001

In Reply Refer To: 652/161R

Mr. James R. Hudson
Director, Atlanta Audit Operations Division
1700 Clairmont Rd.
Decatur, GA 30033

SUBJ: DRAFT REPORT: Combined Assessment Program Review
(Project No. 2000-02679-Re-0305)

Dear Mr. Hudson,

Thank you for the opportunity to comment on the draft report. We have appreciated the Professionalism and courtesy exhibited during the CAP process. We concur with the findings and recommendations contained in the draft report.

RECOMMENDATION 1 – The Medical Center Director take the following actions to strengthen the CNH program.

a. Assure compliance with CNH monthly visitation and annual inspection requirements.

Medical Center Director Comments: Concur. Approval has been given to fill a vacant Social Work position for the Geriatrics and Extended Care Service Line. The Service Line Chief has agreed to relieve the CNH nurse from her duties coordinating the Minimum Data set thereby allowing additional time for monthly visitation and inspections. The nurse will visit each patient monthly, document the visit, and send a log of monthly visits to the Medical Director of the Long Term Care Section. Each nursing home will be inspected annually. A log of the annual inspections will be sent to the Medical Director of the Long Term Care Section.

b. Designate a COTR as required.

Medical Center Director Comments: Concur. To ensure appropriate rates are paid for each patient according to their level of care needs, we have changed our pricing structure for new contracts to the multiple case-mix structure. These contracts will be negotiated within the allowable benchmark rates or contracts will not be offered. This structure reduces the risk to the CNH and therefore should be successful. However, this does not guarantee cost savings but does provide us an excellent opportunity to ensure all rates are paid within the appropriate benchmark rates established for each Care Group.

Medical Center Director Comments

c. Revise CNH policy to be consistent with VA directives.

Medical Center Director Comments: The Geriatrics and Extended Care Service Line will revise and reissue the CNH policy to assure consistency with the monthly visitation requirement as well as to incorporate responsibility for performance improvement data collection and analysis.

Recommendation 2: We recommend that the VAMC Director ensure that inventories are aggressively monitored toward the goal of eliminating unused stock and reducing inventories to 30-day levels.

Medical Center Director Comments: Concur. Two major programs, Total Supply Support and the Prime Vendor Program, each specifically intended to improve inventory management and accountability, were recently implemented. Unfortunately, both had the effect of artificially inflating GIP. Much of the excess stock had languished in the various storage areas for an extended period of time and had been purchased with funds from previous years. For the most part this stock was there because it was no longer the product of choice by the clinical staff and, therefore, was taken off the customers' shelves and put in the warehouse in our Generic Inventory until proper disposal could be arranged. This can often take a considerable amount of Time given other workload and the necessity to comply with long-standing regulatory Requirements. We have steadily reduced the total value of this excess inventory (we estimate its Contribution to the total excess at as much as $597,870) and the remaining overage will be Eliminated within 90 days.

The following processes have been implemented to further improve inventory management and accountability:

- GIP's Inactive Items Report – This report will be reviewed quarterly to keep current with inactive items.
- Physical wall-to-wall Inventories – To be performed quarterly for each A&MMS managed account.
- GIP'S Item Usage Demand Report – To be performed semi-annually. This report will be generated for all areas to encompass one year's usage and levels will be adjusted accordingly.
- GIP Due-In and Packaging Discrepancy Report – Users have been advised to run this report on a weekly basis to keep abreast of delinquent orders and discrepancies with item setup.
- Inventory Managements – Have been counseled on the requirement to reduce excessive inventories and maintain acceptable levels.

However, there will continue to be situations outside our control that will contribute to excess inventory, e.g., National Standardized item contract, minimum purchase requirements, specialty items, other vendor minimum order requirements and vendor lead times. These factors will impact inventory levels even after full implementation of the above initiatives. It is our intention to make these situations the exception rather than the rule.

Betty Bolin Brown
JAMES W. DUDLEY
Director

cc: Veterans Integrated Service Network Director

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