Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review
VA Medical Center
Tuscaloosa, Alabama

Report No.: 00-02003-108

Date: August 18, 2000

Office of Inspector General
Washington DC 20420

VA Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort to ensure that high quality health care is provided to our nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

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

Combined Assessment Program Review
VA Medical Center Tuscaloosa, Alabama

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program review of the VA Medical Center (VAMC) Tuscaloosa, Alabama during the week of June 12 - 16, 2000. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care and quality management, financial and administrative management controls, and fraud prevention.

VAMC Tuscaloosa is a 146-bed primary medical and mental health care facility with a 178-bed nursing home unit. The VAMC's Fiscal Year (FY) 2000 budget was $62.5 million and the staffing level was 827 full-time equivalent employees. In FY 1999 the VAMC treated 2,001 medical and psychiatric patients, 288 nursing home patients, and provided about 115,000 outpatient visits.

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

We suggested that the VAMC Director address patient care oversight issues as follows: (a) eliminate the Medical Acute Care Unit and redirect critically ill patients to other medical facilities; (b) restructure the Residential Program to better support mental health treatment; (c) ensure that clinicians record treatment activities in the medical record; (d) ensure timely and accurate tray preparation and improve quality control in Nutrition Service; (e) contract for additional community nursing home beds; and (f) improve timeliness and documentation of contract care inspection team activities. We also suggested that the VAMC Director address the following treatment environment issues: (a) ensure that wardrobes in patient rooms in Building 61 are secured to the wall to prevent injury; and (b) arrange for emergency communications by patients and visitors in connecting tunnels.

Financial and Administrative Management. The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we suggested that the VAMC Director (a) pursue the opportunity to establish a centralized food processing center; (b) address contracting issues for leased space for non-federal use; (c) ensure that the canteen dining area is kept clean; (d) address inappropriate sales of cigarettes by Canteen Service; (e) dispose of unusable drugs quarterly rather than semi-annually, and (f) enhance various aspects of the agent cashier function. We also recommended that the VAMC Director develop more detailed automated information system contingency plans, and improve controls over inventory management.

Fraud Prevention. Managers fully supported fraud prevention efforts. During the review we provided fraud and integrity awareness training for about 291 VAMC employees (about 35 percent of all employees). We tested two program areas for indications of fraudulent activity and as a result identified one workers' compensation case for further inquiry. In a third program area involving an ongoing investigation, we identified an additional 14 veterans who were victims of a fraud scheme perpetrated by a former employee.

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

Table of Contents

Introduction

VA Medical Center Tuscaloosa

VA Medical Center (VAMC) Tuscaloosa provides primary medical and mental health care, as well as nursing home care. The facility does not operate any satellite or community-based outpatient clinics. The VAMC is one of eight medical centers in Veterans Integrated Service Network (VISN) 7. The primary service area for VAMC Tuscaloosa is western Alabama, with most of the veteran population residing within a 100-mile radius of the facility.

Affiliations and Programs. The VAMC is affiliated with the University of Alabama College of Community Health Sciences; the University of Alabama Schools of Dentistry, Medicine, and Optometry; and 31 colleges and universities in Allied Health Science Programs such as nursing, social work, psychology, pharmacy, dietetics, rehabilitation, computer sciences, and speech pathology. The VAMC is participating in 13 national research studies.

Resources. The FY 2000 budget is $62.5 million. Staffing totals 827 full-time equivalent employees, including 17 physicians. The VAMC has 30 medical, 116 psychiatric, and 178 nursing home beds authorized, as of the third quarter, FY 2000.

Workload. In FY 1999, the VAMC provided 45,644 inpatient days of care to 2,001 medical and psychiatric patients and 61,920 inpatient days of nursing care to 288 nursing home patients. The average daily census of inpatients was 24 medical, 100 psychiatric, and 169 nursing home patients. The outpatient care workload was about 115,000 visits.

Objectives and Scope of Combined Assessment Program

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

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

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

- Acute Care Medicine
- Physical Medicine & Rehabilitation
- Substance Abuse Treatment Program
- Ambulatory Care Services
- Clinician Staffing
- Community Inspection Team Process
- Radiology Service
- Acute & Long-term Mental Health
- Research Service Informed Consent
- Post-traumatic Stress Disorder Program
- Geriatrics and Extended Care
- Lodge/Hoptel
- Vocational Rehabilitation
- Quality Management Program
- Contract Nursing Home Program
- Nutrition Services
- Laboratory & Pathology Service
- Pharmacy Service
- Autopsy Rates

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
- Lease Agreements
- Community Nursing Home Contracts
- Printing Practices
- Automated Information System Security
- Building and Grounds Maintenance
- Medical Care Collection Fund
- Inventory Management
- Means Test Certification
- Purchase Card Program
- Accounts Receivable
- Research Informed Consent
- Unliquidated Obligations
- Canteen Services
- Centralized Food Processing

Fraud Prevention. We conducted 5 fraud and integrity awareness briefings for over 290 VAMC employees (35 percent of the staff). The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery; and included handouts of a Fraud Awareness Packet and a flyer on how to report fraud, waste, or abuse in the VA Workers' Compensation Program.

We also reviewed records and met with employees in the beneficiary travel office to assess the potential for possible beneficiary travel fraud, and met with the Office of Workers' Compensation Program Specialist to assess indications of fraud in that program. In support of an ongoing investigation, we reviewed patient records and

identified an additional 14 veterans who were victims of a fraud scheme perpetrated by a former employee.

Scope of Review. The CAP review generally covered VAMC operations for FY 1999 and the first half of FY 2000. The review was done in accordance with draft Standard Operating procedures for the VA Office of Inspector General CAP program.

Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

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

The QM Program Was Comprehensive and Well Organized. The VAMC's QM Program included utilization review, performance improvement, risk management, and administrative investigations. Areas that we reviewed included: incident reports, administrative investigations, root-cause analyses/focused reviews, tracking of external review recommendations, and tort claims. Our review found that QM employees effectively identified opportunities for improvement, tracked results, and ensured appropriate follow up on recommended corrective actions. We found that QM employees were proactive, conducting 100 percent utilization reviews and working closely with ward employees to identify potential complaints, errors, or vulnerabilities. QM employees conducted ongoing education programs for medical center employees on incident reporting and documentation. We suggested that the QM department make a concerted effort to identify and analyze near misses (events that could have had adverse patient care consequences but did not) which may further improve patient care processes.

Most Patients and Employees Were Satisfied With the Quality of Care. We interviewed VAMC top managers, clinical managers, and 61 patients. We also sent survey questionnaires to 270 randomly selected full-time employees, 144 (53 percent) of whom responded. The results of our survey and interviews showed that 82 percent of the VAMC employees whom we interviewed and surveyed, and 95 percent of the patients whom we interviewed, rated the quality of care provided to patients as good, very good, or excellent. Of the patients whom we interviewed, 98 percent would recommend care at the VAMC to family members or friends, but only 72 percent of the employees whom we interviewed and surveyed would make such a recommendation.

Fully Electronic Medical Records Promoted Continuity of Care. VAMC Tuscaloosa's administrative and clinical patient records were fully computerized, including scanned images of patients' informed consents, advance directives, and patient registration documents. Employees fully supported the electronic system. The electronic medical record also eliminated the problems of low medical record retrieval rates, misfiling, and the need to relocate old data from treatment records. We found that the electronic medical records were well organized, easy to review, and user friendly.

Researchers Effectively Recorded Signed Patient Consents for Participation in Research Projects. Research Service administered 19 research projects involving 138 patients. We reviewed a sample of 20 patients' records and associated administrative files from 12 of the research projects to determine if patients had signed consent forms and researchers had recorded the consent process as required. Records showed that principal investigators appropriately described the issues of consent to research participants, and filed signed consent forms in administrative files and patients' medical records as required.

Top Managers Should Address Various Patient Care Oversight and Treatment Environment Issues

During the review, we noted that managers were taking corrective actions on several issues in the Mental Health Service Line (MHSL) which we supported and which did not warrant suggestions or recommendations on our part. Other patient care oversight and environment issues did not require individual recommendations, but warranted medical center managers' attention.

Managers Were Addressing Morale and Leadership Issues in the MHSL. Multiple employees reported low morale in the MHSL. The transition to the service line model and the loss of key personnel, including the service line director, reportedly contributed to this problem. Recruitment and retention of psychiatrists, which is a problem for VA nationally, has been difficult. Several employees expressed concerns about poor communication between upper level MHSL management and employees, and reported that MHSL line employees often had no sense of the mission or direction of the service line. MHSL employees were unclear about the roles and responsibilities of some key positions and were unclear about the chain of command. We also observed a lack of "buy-in" by employees regarding new program directions.

Medical center managers were aware of the MHSL's leadership issues and were actively addressing these concerns. A new MHSL Director transferred to VAMC Tuscaloosa in July 2000. Nurse managers were meeting weekly to improve communication and address problems related to communication, orientation and training, admission and discharge policies, and unit designations.

Management Should Eliminate the Medical Acute Care Unit and Redirect Critically Ill Patients to Other Medical Facilities. In the past several months, a series of events compromised VAMC Tuscaloosa clinicians' ability to provide adequate intensive medical treatment and management for critically ill patients on their 10-bed Medical Acute Care Unit. Contributing factors to this situation included:

- Loss of experienced critical care nurses due to transfer, separation, and retirement.
- Low volume of high acuity patients did not allow nurses to obtain and maintain their competencies.

- Nursing Education Section's failure to provide critical care competency skills training (ventilators, chest tubes, telemetry and IV hemodynamic control drips).
- Retirement of the Medical Acute Care Unit's hospitalist in February 2000, which necessitated that outpatient primary care physicians provide inpatient acute care.

Top managers recognized that these factors potentially placed patients and employees at increased risk for incurring adverse events. A proposal to close the Acute Medical Service and transfer patients who required complex medical treatment to VAMC Birmingham was under consideration. We concur with managers' efforts to close the acute care beds given the impaired staffing considerations and low projected workload. In the interim, clinicians should transfer critically ill, unstable patients to an appropriate acute care facility. At the time of our review there were no patients in this category.

Managers Need to Restructure the Residential Program to Better Support Mental Health Treatment. VAMC Tuscaloosa did not have a domiciliary or Psychosocial Residential Rehabilitation and Treatment Program (PRRTP), and was utilizing its Lodge/Hoptel Program to provide residential support to patients who were receiving outpatient mental health services. Patients who were residing in the Lodge were typically enrolled in the Substance Abuse Treatment Program, the Vocational Rehabilitation Program, the Post-traumatic Stress Disorder Program, or the Genesis Program. The Lodge's average daily census for May 2000 was 78 patients, and the occupancy rate was 90.2 percent.

It appeared that VAMC Tuscaloosa managers were liberally interpreting the criteria and guidelines outlined in M-1, Part 1, Chapter 1 (Change 17) on *Lodging of Patients* which states:

> *"A patient who reports to a VA medical facility for outpatient examination or treatment and is held over for the convenience of the VA may be furnished lodging for either medical or administrative reasons."* The Manual also states that: *"… if a VA health care facility Director or designee determines that inclement weather, irregular transportation or other compelling reasons prevent an applicant's departure until the next day… the Director or designee may authorize lodging…"*

Managers asserted that housing patients in the Lodge while they attended outpatient treatment was a cost-effective alternative to domiciliary care. The local policy on patient lodging reflected this enhanced use and allowed for extended stays as directed by the patient's treatment team. The local policy was also clear that no treatment services occurred in the Lodge itself, and that the Lodge provided accommodations only. Because the Lodge was not a treatment or therapeutic program, it was not subject to the more stringent Veterans Health Administration and Joint Commission on Accreditation of Healthcare Organizations guidelines of a domiciliary or PRRTP.

Despite the good intent, VAMC managers may be encouraging uncoordinated care of mental health patients who reside in the Lodge. Lodge assistants supervised patients and observed interactions that could be highly significant to the treatment process, yet there was no formal venue or procedure to share this information with treatment team members. If managers elect to continue the current practice, clinicians should include Lodge assistants in the treatment and goal planning processes so that their efforts can appropriately support patients. By not imposing strict guidelines related to communication and collaboration between Lodge and treatment team members, managers were encouraging disjointed care. Managers should devise a structured residential care program that supports mental health programs and fosters communication and collaboration among all treatment components.

Clinicians Need to Record Treatment and Discharge Planning Activities in the Medical Record. Overall, medical record documentation was comprehensive and generally reflected timely assessments, continuity of treatment processes, and proper discharge planning. Our review of 45 randomly selected inpatient and outpatient primary medical and mental health records revealed that:

- 100 percent reflected appropriate discharge planning.
- 91.1 percent included psychosocial assessments.
- 88.9 percent included nutritional assessments.
- 86.3 percent reflected completion of timely Histories & Physical Examinations.
- 84.1 percent reflected completion of timely nursing assessments.
- 80.0 percent reflected discussions of advance directives.

In addition, we reviewed 15 nursing home care medical records for different criteria, including documentation of quarterly care plans, evidence of patient/family involvement in treatment plans, and documentation of discharge plans. These record reviews found that:

- 100 percent had quarterly interdisciplinary care plans.
- 100 percent reflected family involvement in care planning.

Even though the records that we reviewed were generally well maintained, we found that 28.3 percent of the inpatient and outpatient primary medical and mental health records lacked evidence of interdisciplinary treatment planning. Forty percent of the nursing home care medical records lacked any evidence of appropriate discharge planning, and 64 percent did not contain any evidence that clinicians involved the patients in treatment planning. Medical center managers should ensure that clinicians record treatment activities in medical records as appropriate.

Nutrition Service Managers Need to Ensure Timely and Accurate Tray Preparation and Improve Quality Control. Six employees reported to us that they were unable to request special diet orders and expect them to be implemented by the next mealtime. They told us that typically it required 24 hours on weekdays and 48 hours on weekends for new diet orders to take effect. The Director, Nutrition Service, denied these

assertions. Managers should evaluate these concerns for validity, and initiate remedial action to either assure timeliness of special diet orders, or provide training to employees who don't use the proper procedure for ordering special diets.

During our visit, we inspected four randomly selected meal trays in the nursing home care unit (NHCU), two of which had minor errors. On another date, it appeared that three NHCU patients did not receive their evening meal trays, and NHCU clinicians assembled their meals from other patients' trays. None of these were new patients. In another instance, employees told us that a diabetic patient had been inappropriately given sugar packets and jelly. The Nutrition Services' quality control monitor on meal tray errors showed that tray errors increased from 6 percent in April 2000, to 24 percent in May 2000. Nutrition Service's internal standard for acceptable tray errors was 10 percent or less. Employees who are responsible for meal trays should be trained on quality control guidelines to ensure accurate tray preparation.

We reviewed the food service galley on ward 61N and found bananas that were overripe and infested with fruit flies. These bananas had been washed and prepared for patients. Several food service employees told us that it was not uncommon for Nutrition Service to accept poor quality produce. The VAMC contracted locally for produce and had on occasion returned produce for credit. Nutrition Service managers need to ensure that employees follow established guidelines for inspection of fresh produce.

The VAMC Should Contract With More Community Nursing Homes. VAMC Tuscaloosa's NHCU had an extensive waiting list of more than 50 patients who were awaiting nursing home beds. In several cases, the patients had been on the waiting list in excess of 1 year. The VAMC had only three contract nursing homes (CNHs) and three active CNH patients. None of the CNHs were located in the same county as the VAMC, which was where most of the patients on the waiting list resided. The CNH coordinator could not provide us with any documentation to show that anyone had conducted recruitment efforts with area CNHs for several years. Given the aging veteran population and the already extensive waiting list for long-term care beds, medical center managers should increase their efforts to develop CNH contracts in the local area.

Contract Care Inspection Team Members Need to Complete and Document Annual Inspections in a Timely Manner. Veterans Health Administration policy requires that medical center managers conduct annual inspections of all CNHs and community residential care (CRC) homes to ensure that they meet safety, quality, and therapeutic standards. VAMC Tuscaloosa had about 30 sponsors in its CRC Home Program and contracts with 3 CNHs. We reviewed 10 CRC sponsor files and the 3 CNH files to determine the timeliness of VA inspections and the degree of VA clinicians' follow up on deficiencies that inspection team members identified. We found that in 6 of 10 CRC sponsors' files and in all 3 CNH files, the latest documented inspections were more than 1 year old. The inspection files frequently did not contain input by all four disciplines that participated in the inspection (safety officer, nurse, social worker, and dietitian). The records also showed that team members did not follow up on identified

deficiencies and corrective actions in several cases. Annual inspections and regular follow up of deficiencies will promote safety and appropriate care in community placement settings.

Managers Should Address Two Safety Concerns in the Medical Center. Two safety concerns came to our attention that warrant management attention:

- The wardrobes in the patient rooms in Building 61 were freestanding units that could be easily moved or tilted. Patients could inadvertently pull a wardrobe over, injuring themselves or another patient or employee. Engineering employees should secure the wardrobes in some manner to prevent movement.

- VAMC Tuscaloosa has a large campus with multiple buildings that are connected by tunnels. None of these tunnels had panic buttons or other alarm systems, and patients and family members could not access the phones in these tunnels. Managers should devise a method to ensure that patients and visitors have access to emergency telephone communications or other alarm systems in connecting tunnels.

Financial and Administrative Management

Management Controls Were Generally Effective

VAMC 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.

The VAMC Generally Met VISN Medical Care Collection Fund (MCCF) Goals. VISN 7 reports showed that VAMC Tuscaloosa had the most effective MCCF program in the VISN, leading the other facilities in exceeding four of the five VISN goals (data base collection, billing lag time, outstanding receivables, and percentage of denied days). Because it was not meeting the VISN goal for cumulative MCCF collections, the facility recently initiated a plan to reduce the backlog of unbilled claims. As a result, inpatient unbilled cases have been reduced to zero, and efforts are now focused on reducing unbilled outpatient claims.

Controls Over the Purchase Card Program Were Effective. From October 1998 through March 2000, cardholders processed more than 12,500 purchase transactions totaling about $4.9 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. Managers discussed any potential discrepancies with the cardholders and effectively followed up on issues identified as a result of their reviews. Quarterly quality reviews encompassed all purchase cardholders. Our review of 10 randomly selected purchase cardholders showed that, from FY 1999 through the second quarter of FY 2000, only two transactions were not reconciled within 5 days by two cardholders, and only two transactions were not approved within 14 days by approving officials.

VAMC Tuscaloosa's Contract Community Nursing Home Care Rates Met VA Guidelines. VA policy requires contracting officers to award contracts for community nursing home care not to exceed specified percentages of nursing homes' state-approved Medicaid rates. The rates for VAMC Tuscaloosa did not exceed suggested rates.

Employee Accounts Receivables Were Current and Followup by the Accounting Section Was Timely. Only two former employees owed any significant debts, both accounts involving repayment of bonus incentives. Fiscal Service was recovering a debt of $10,577 from one former physician under a repayment plan, with $2,162 remaining to be recovered. Another debt totaling $31,795 was created in December 1999 and was pending a waiver decision in VA Central Office.

Employees Effectively Administered Means Testing. The facility ensured that applicants for care had their applications complete, accurate, and signed based on our review of 182 means tests. We tested the reliability of the means tests data the facility reported for VHA's January 2000 Signed Means Test Validation Project, which covered means test years 1993 through 1999. We validated that all but 2 of the 62 means tests randomly selected were on file and signed, as reported. The 2 means tests not on file occurred in 1996 and 1998, respectively. We also randomly selected means tests reported to the Health Eligibility Center for the means test years 1999 and 2000. We reviewed 58 of 254 means tests for 1999 and 56 of 474 means tests for 2000. We found that, for both years, all means tests were on file and appropriately signed by the veterans.

The Facility Did Not Incur Commercial Printing Costs. Generally, any printing done off station by other than the Government Printing Office must be reported to the VA Office of Administration semi-annually. Single line items exceeding printing costs of $1,000 must also be pre-approved by the Government Printing Office. From October 1998 through May 2000 the facility did not use any off-station printing services.

Suggestions for Management Attention

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

Managers Should Pursue the Opportunity to Establish a Centralized Food Processing Center at VAMC Tuscaloosa. Nutrition Service at VAMC Tuscaloosa had operated an advanced food processing and delivery system for about 2 years. This system allowed the facility to reduce staffing by 9.5 full-time equivalent employees and to improve the quality of food served to its patients. VAMC Tuscaloosa has the capability to centrally produce food products for distribution to other VA facilities; however, managers had not recently pursued this concept with other nearby VA facilities. Although VAMC Birmingham implemented their own system this year, the VA facilities in Montgomery and Tuskegee, Alabama, had not implemented an advanced food processing and delivery system. A national OIG audit showed that a centralized food processing center that services other VA facilities decreases food production costs at the participating facilities, and improves the productivity and cost effectiveness of food processing at the production facility.

According to the Director, Nutrition Service, the facility could accommodate food production for the other two facilities with minimal capital investment (primarily consisting of a pumping station and a tumble-chill cook tank, and minimal staffing increases). The cost of capitol investment at VAMC Tuscaloosa would be recovered in 2 to 3 years through staff reductions in the food processing activities at VAMCs Montgomery and Tuskegee. VAMC Tuscaloosa managers should initiate discussions with the VISN Director to assess the potential for developing the VAMC Tuscaloosa program into a centralized food-processing center.

Management Should Address Contracting Issues for Leased Space for Non-Federal Use. VAMC Tuscaloosa developed a variety of arrangements to dispose of or make more effective use of underutilized or excess land tracts. These arrangements significantly contributed to a strong partnership with the Tuscaloosa community and enhanced the type and range of community benefits available to the local veteran population. For example, land tracts have been sold, ceded, or leased that allowed:

- Construction of a fire department adjacent to the VAMC that provides fire protection services to VA.
- Implementation of a community recycling center.
- Construction of a community civic center.
- Construction of a city operated water tower.
- Transfer of a golf course to community operation.
- Provision for an adjacent mental health facility to plan construction of a recreation center.

In a similar effort, VAMC Tuscaloosa managers arranged for a local community mental health center to lease most of the vacant space located on the third floor of Building 1 to operate:

- A 10-bed mental health crisis management center (3,901 square feet at $8.50 a square foot), effective December 1999.
- An adult outpatient services center (3,620 square feet at $6.50 a square foot), effective May 2000.
- An adult substance abuse program (2,313 square feet at $6.50 a square foot), effective May 2000.

We concluded that these were appropriate ways to dispose of underutilized space that resulted when VAMC Tuscaloosa transitioned from inpatient care to ambulatory care treatment. The leases provided revenue to offset fixed maintenance and utility costs, and supported health care programs used by many community veterans. Nevertheless, some aspects of the arrangements warranted management attention:

- There was no evidence in contract files that the lessee maintained general liability insurance coverage as required by the contract. The VAMC Contracting Officer (CO) should require the lessee to provide evidence of the insurance coverage required by the lease, and assess the adequacy of the amounts and types of coverage required by the lease. The CO should also ensure that the liability policy does not lapse in the future.

- The justifications for the two contracts that were awarded in May 2000, outlined the fair market value of the space as $8.50 per square foot per year, the same rate as contracted in December 1999. However, the monthly user fee described in the contract was computed using $6.50 per square foot per year. Contract file records did not provide any justification for using the lower rate. VAMC Tuscaloosa's marketing specialist explained that he agreed to reduce the lease

rate to $6.50 per square foot in a "gentleman's agreement" with the clinic, because the programs covered by these contracts only used their space during part of the day rather than 24 hours a day. In addition, some of the space was effectively unusable so the rate had been reduced to account for such lost space utilization.

Contract rates should be well documented. Space is not typically leased based on the number of hours a day that it is in use unless the leasing source would have use of the space for its own purposes for those other hours. Similarly, if the reduced rate is justified based on unusable space within the program area, then the amount of usable square footage should be defined and explained in the market survey and the fair market value adjusted as appropriate.

The Canteen Dining Area Should Be Kept Clean. Building and grounds maintenance and housekeeping was excellent with the exception of the Canteen Service dining area. Both interior design and landscaping significantly contributed to the aesthetics of the facility and gave a positive impression of the VA to facility visitors. However, during our review we regularly noted that Canteen Service employees did not maintain a clean dining area. For example, late on Tuesday afternoon, and on Wednesday and Thursday mornings during our review, most of the tables had paper litter, drink container rings and spills, and food crumbs on them. Similarly, the floor was excessively littered with paper and food debris. Unclean eating conditions do not contribute favorably to the facility's image, and may have contributed to declining Canteen food sales. Managers should contact VA Central Office Canteen officials to request an unannounced inspection of the entire Canteen area.

Canteen Service Should Not Sell Cigarettes to Employees or Patients. VA policy forbids sales of cigarettes to employees, outpatients, and most inpatients. Sales to some inpatients may be permissible where required by the VAMC and as set forth by the Medical Center Director.

VAMC Tuscaloosa's Non-Smoking Policy allows Canteen Service to sell cigarettes to acute care mental health patients and terminally ill, or severely debilitated patients. Justification for allowing the patient to smoke must be documented in the medical record by a physician. If an order is written for indoor smoking, the patient will be observed at all times by nursing personnel.

The retail store was selling cigarettes to employees and patients under loosely followed local policy that permitted sales to acute care mental health inpatients. Local policy did not sufficiently outline the requirements under which Canteen Service was allowed to sell cigarettes to patients or the procedures for Canteen Service to follow in making such sales. As a result, essentially anyone wearing an inpatient identification wristband could buy cigarettes at the retail store. Retail store employees also allowed outpatients who were occupying the facility's Hoptel to buy cigarettes, and some employees said that they had bought cigarettes, although Canteen Service employees told us that sales to employees were not allowed. Managers should develop local policy that clearly

outlines the circumstances and practices under which Canteen Service may sell smoking materials.

Pharmacy Service Should Dispose of Unusable Drugs Quarterly. Management controls over Pharmacy Service security were generally effective. Employees conducted monthly unannounced inspections of all Schedule II-V controlled substances as required, inspectors received appropriate training, and managers followed guidelines for appropriately assigning employees to inspection teams. However, under local policy, excess or expired controlled substances were disposed of at 6-month intervals, while VA standards require disposal quarterly.

Physical security requirements were met with the exception of the use of wood doors in Pharmacy Service. VA requires that Pharmacy Service have steel doors. The overall security achieved through compliance with other security measures such as key control, restricted overhead access, and use of alarms did not warrant currently replacing the existing doors. However, any future Pharmacy renovation should include the installation of steel doors. Managers should revise local policy to require quarterly disposal of excess or expired controlled substances.

Managers Should Enhance Various Aspects of the Agent Cashier Function. Various aspects of the agent cashier function required management attention:

- The dates and times of unannounced audits were not adequately varied to enhance surprise.
- The level of the agent cashier's advance slightly exceeded the facility's needs.
- Responsibility and accountability for the advance was not transferred to the alternate agent cashier for at least a 2-week period.
- The door to the agent cashier's office did not meet security requirements.

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 May 22, 2000. Audits were repeated from 77 to 89 days after the prior audit. To ensure surprise and provide more effective control, managers should schedule six audits a year with at least one audit held within 30 days of the prior audit. When we brought this issue to management's attention they planned to correct the condition and conducted an unannounced audit on May 23rd, 20 days following the prior unannounced audit. The facility met other guidelines relating to separation of duties and training for agent cashier audits.

Cash Advance – The agent cashier's cash advance may exceed VAMC requirements. The agent cashier's advance was $29,000, but from January 1 through March 31, 2000, the total cash on hand and cash on deposit never fell below $4,000 and generally ranged from $12,000 to $19,000. Excessive cash advances needlessly tie up funds that

could be used more effectively for other purposes. When we brought this issue to the attention of Fiscal Service managers they planned to reduce the advance by $3,000 for 90-days to assess any impact on cash management. The advance would be adjusted based on the results of this test.

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. However, the VAMC Tuscaloosa Agent Cashier preferred to take only 1-week of annual leave each year. Therefore, during the current calendar year, responsibility and accountability was only transferred during the 1-week period when the agent cashier was on annual leave. During the "second week" the Agent Cashier was designated the alternate agent cashier, but actually conducted 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 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.

Physical Security – The physical security of the agent cashier function generally met standards, although the door to the agent cashier's office was not made of steel. The overall security achieved through compliance with other security measures such as key control, restricted overhead access, and use of alarms did not warrant currently replacing the existing door. However, any future renovation of the space should include installation of a steel door.

Recommendations for Improving Management Controls

Managers Should Develop More Detailed Automated Information System (AIS) Contingency Plans. With the exception of contingency planning, VAMC Tuscaloosa generally met guidelines for protecting AIS resources from unauthorized access, disclosure, modification, destruction, and misuse in the eight primary elements applicable to the security of automated information. Facilities are required to develop and implement AIS contingency and recovery plans to reduce the impact of disruptions in services, to provide critical interim processing support, and to resume normal operations as soon as possible. VAMC Tuscaloosa's contingency and recovery plans generally did not:

- Identify mission-critical functions.
- Detail specific tasks to be completed in a recovery process.
- Designate alternative processing sites.
- Establish off-site storage for critical backup files.
- Identify key personnel to be part of disaster recovery teams.

Contingency plans were prepared for the following end user program areas: Office of the Director, Resource Management, Facility Management, Decision Support System

(DSS), Health Information Management, Primary Care Service, Mental Health Service, Clinical Support Service, and Nutrition Services. However, Service Line Directors did not update their plans annually as required by local policy, and some program areas and operating systems were not covered under the plans. Most of the plans were dated in 1997, the general format differed significantly among program areas, and the plans were incomplete. For example, the DSS contingency plan consisted only of a single paragraph.

AIS security and requirements for contingency planning are described in several dozen VA policies. Consequently, the effectiveness of contingency planning could be improved by assigning responsibility for oversight to a single manager knowledgeable in the broad scope of requirements. The manager should monitor service line AIS activities and ensure facility managers' understanding and compliance with VA Central Office and other federal requirements. Service lines would benefit from detailed direction in the minimum requirements necessary to effectively develop and implement plans for dealing with emergency disruption in automated systems.

Recommendation 1 – The Director, VAMC Tuscaloosa should improve oversight of AIS contingency planning and ensure:

a. All applicable program areas and automated systems are addressed.

b. Plans are consistent and address all required elements of disaster planning.

c. Plans are regularly revised and updated.

Medical Center Director Comments

The Director concurred with the finding and recommendation. A Contingency Council will be established to facilitate the development of a facility contingency plan covering all program areas and automated systems. The Council, which will consist of two representatives from each Service Line, will ensure plans are regularly reviewed and updated, and will report findings and any corrective action to the Information Management Planning Board.

Office of Inspector General Comments

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

Managers Should Improve Control Over Inventory Management. Employees were not using the Generic Inventory Package (GIP), an automated supply inventory system, to manage the Supply Processing and Distribution (SPD) inventory, and did not use GIP effectively to control operational stock (bulk inventory) and process stores (office supplies) inventory. Veterans Health Administration guidelines require use of GIP to manage and control supply inventories, but GIP data must be accurate for the

program's automated management features to identify excesses and shortages. Inventories should not generally exceed a 19 to 30-day supply.

VAMC Birmingham operated the warehouse located at VAMC Tuscaloosa and generally oversaw the supply services programs jointly for the two facilities. VAMCs Birmingham and Tuscaloosa's operational stock contained 308 line items valued at about $191,000. VAMC Tuscaloosa's process stores inventory contained 181 line items valued at about $36,000 (VAMC Birmingham did not have a process stores inventory).

SPD Inventory – GIP was not used for SPD inventory at the time of our review, but Acquisition and Material Management Service employees were in the process of inputting SPD inventory records into the system. They had been developing the database for about 12 months. Typically, the SPD inventory represents a significant portion of a facility's inventory and can benefit the most from automated inventory management. Increased management attention should be given to establishing GIP control over SPD inventory as soon as possible.

Inventory Errors – We physically inventoried a judgment sample of 20 line items valued at $33,214 that were included in the GIP inventory of 489 line items valued at about $227,000. In 6 of the 20 line items, the GIP inventory balance did not match actual stock on hand. The net difference in the book value of the 20 items was $1,643, causing the inventory to be understated by 5 percent ($1,643/$33,214). Therefore, the book value of the entire inventory, adjusted for the 5 percent error, would be about $238,000.

Excess Stock – We assessed stock levels in the 489 line items reported in GIP. The reported inventory exceeded a 30-day supply in 424 line items (88 percent) and the value of stock in excess of 30 days supply totaled $135,869 (not adjusted for the 5 percent understatement of the inventory discussed above). Warehouse managers told us that they were not aware that VHA recommended stock levels below 30 days. They also told us that the using service sets the inventory levels, and that they try to maintain the stock levels requested. Although various management reports were available under the GIP system of inventory control, employees did not use them to consistently assess and manage inventory levels. Warehouse managers agreed that many of the stock levels were too high based on the level of utilization.

Recommendation 2 – The Director, VAMC Tuscaloosa should ensure that:

a. The GIP Program is effectively used to automate inventory management.

b. The accuracy of the GIP inventory is regularly validated until there is assurance that effective program controls exist to represent an accurate database.

c. Inventory is aggressively monitored toward lowering most line items below a 30-day supply.

Medical Center Director Comments

The Director concurred with the finding and recommendation. The Generic Inventory Package will be implemented and appropriately managed for all recurring supply inventories. A wall-to-wall inventory of all warehouse stock will be completed every six weeks until a 95 percent accuracy rate is achieved. The stock level is currently being reviewed and levels adjusted to lower the inventory to a 30-day supply.

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 Prevention

Managers Fully Supported Fraud Prevention and Detection

VAMC managers fully supported fraud prevention and detection efforts. They encouraged employees to report suspected fraud, waste, and abuse to the OIG, and they had personally made referrals to the Office of Investigations in a timely manner when circumstances required referral. The OIG's hotline referral number was posted for the information of employees, patients, and visitors, and 291 VAMC employees attended our 90-minute fraud and integrity awareness training sessions during our review.

While on site we reviewed records in two program areas that present high risk of fraud, waste, or abuse to specifically identify potential fraud cases, as discussed below:

- **Worker's Compensation.** During the 9-month period from July 1, 1999, to March 31, 2000, VAMC Tuscaloosa was charged about $455,000 in Office of Worker's Compensation Program (OWCP) costs ($100,891 in medical costs and $353,849 in compensation costs). We reviewed a judgment sample of nine workers compensation cases with records of the Social Security Administration's Master Death List to determine whether any of the OWCP recipients were deceased. No questionable cases were identified. We also made wage inquiries on 16 judgmentally selected workers compensation cases, and identified one case for further inquiry. We requested the OWCP file for review to determine if the employee's wages were reported to the Department of Labor. We will follow up accordingly.

- **Beneficiary Travel.** We met with employees in the beneficiary travel office to identify any individuals who submitted questionable beneficiary travel claims. No questionable cases were identified.

In a third program area involving an ongoing investigation that facility managers had referred to the Office of Investigations, we identified 14 additional veterans who were victims of a fraud scheme perpetrated by a former employee. We scheduled follow-up investigative work on these cases as appropriate.

Fraud and Integrity Awareness Briefings

As part of the CAP review, an Office of Investigations agent conducted five 90-minute Fraud and Integrity Awareness briefings, which 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 question and answer opportunities. About 291 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, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

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

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

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

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

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center Tuscaloosa, Alabama

Project Number: 2000-02003-R3-0261

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
2	Reduction in stock inventory	$135,869	
Total		**$135,869**	

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: August 1, 2000

From: Medical Center Director (00/679)

Subj: DRAFT REPORT: Combined Assessment Program Review - VA Medical Center, Tuscaloosa, Alabama (Project No. 2000-02003-R3-0261)

To: Assistant Inspector General for Auditing (52)

1. Enclosed is our response to the draft report of the Combined Assessment Program (CAP) Review conducted at this Medical Center. We have reviewed the report findings and concur with the two recommendations (Attachment). We also concur with the OIG estimate of monetary benefits regarding reduction in stock inventory.

2. Although not required for reporting purposes, Tuscaloosa VA Medical Center is in agreement with the suggestions made by the CAP team. Appropriate follow-up actions are underway.

3. If you require any additional information or further clarification, please feel free to contact Elois Prude, Health System Specialist, at (205) 554-3575.

/s/
W. KENNETH RUYLE

Attachment

Medical Center Director Comments

Recommendation 1

We concur with this recommendation and will implement the following corrective actions:

1. A facility Contingency Council will be established and its membership approved by the Medical Center Director. This council will consist of two representatives from each Service Line under the chairmanship of the Information Security Officers. This council will facilitate the development of "task oriented" ADP contingency plans for the Medical Center covering all program areas and automated systems.

2. A complete AIS Contingency Plan will be developed by September 30, 2000.

3. The Council will ensure plans are regularly reviewed and updated. This Council will report findings and any corrective action to the Information Management Planning Board.

Recommendation 2

We concur with this recommendation and will implement the following corrective actions:

1. The Generic Inventory Package (GIP) will be implemented and appropriately managed for all recurring supply inventories at this Medical Center. The Director, Atlanta Network has issued the Network Inventory Management Policy (10N7-028) which requires implementation throughout the network. A detailed implementation plan will be submitted to the Director, Atlanta Network by August 11, 2000.

2. Implementation of medical inventory will be completed by June 2001.

3. Implementation of non-medical inventory will be completed by September 30, 2001.

4. A wall-to-wall inventory of all warehouse stock will be completed every six weeks and reviewed by A&MM management. This review will continue until such time as we achieve a 95% accuracy rate.

5. The stock level is currently being reviewed and levels adjusted. We expect to have our levels down to the desired 30-day requirement by 10/1/00.

Final Report Distribution

VA Distribution

The Secretary of Veterans Affairs
Acting Under Secretary for Health (105E)
General Counsel (02)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
Deputy Assistant Secretary for Congressional Operations (60)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (90)
Director, Office of Management and Financial Reports Service (047GB2)
Chief Network Officer (10N)
VHA Chief Information Officer (19)
Veterans Integrated Service Network Director (10N7)
Director, VA Medical Center Tuscaloosa, Alabama (00/679)

Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office

The Honorable Richard Shelby, United States Senate, Washington, DC
The Honorable Jeff Sessions, United States Senate, Washington, DC
The Honorable Earl Hilliard, House of Representatives, Washington, DC
The Honorable Spencer Bachus, III, House of Representatives, Washington, DC
Chairman, Committee on Governmental Affairs, United States Senate
Ranking Member, Committee on Governmental Affairs, United States Senate
Chairman, Committee on Veterans' Affairs, United States Senate
Ranking Member, Committee on Veterans' Affairs, United States Senate
Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, United States Senate
Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, United States Senate
Chairman, Committee on Veterans' Affairs, House of Representatives
Ranking Member, Committee on Veterans' Affairs, House of Representatives
Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, House of Representatives
Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, House of Representatives

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 two fiscal years after it is issued.