# Department of Veterans Affairs
# Office of Inspector General

# Combined Assessment Program Review of the VA Medical Center Fayetteville, Arkansas

**Report No. 03-01855-179** **September 30, 2003**

**VA Office of Inspector General**
**Washington, DC 20420**

# Office of Inspector General
# Combined Assessment Program Reviews

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

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

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

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# Executive Summary

## Introduction

During the week of June 23-27, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Fayetteville, Arkansas VA Medical Center (VAMC), which is part of Veterans Integrated Service Network (VISN) 16. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 212 VAMC employees.

## Results of Review

We found that the QM program provided effective oversight of medical care operations. We also found that the VAMC had established effective procedures and controls to ensure that purchases were appropriate and were meeting the requirements of the Purchase Card Program. In addition, we found that information technology (IT) security was generally effective. To improve operations, VAMC managers needed to:

- Reduce excess medical and engineering supply inventories and strengthen inventory management controls.
- Improve controlled substances inspection procedures and correct security deficiencies.
- Improve documentation of the contract award process.
- Restrict laboratory access to authorized personnel.

## VISN and VAMC Directors Comments

The VISN 16 and the VAMC Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendices A and B, pages 7-10, for the full text of the Directors' comments).

*(Original signed by:)*
RICHARD J. GRIFFIN
Inspector General

# Introduction

## Medical Center Profile

**Organization.** The VAMC provides inpatient and outpatient treatment in Fayetteville, Arkansas and provides outpatient care at community-based outpatient clinics (CBOCs) in Fort Smith and Harrison, Arkansas, and Mt. Vernon, Missouri. The VAMC is part of VISN 16, and during fiscal year (FY) 2002, served a population of 135,124 veterans in a primary service area that included 10 counties in Arkansas, 10 counties in Missouri, and 2 counties in Oklahoma.

**Programs.** The VAMC has 51 beds and provides acute medical, surgical, and psychiatric inpatient services. Outpatient programs include primary and specialty care, ambulatory surgery, and mental health. Specialty clinics include cardiology, urology, diabetes, and women's health.

**Workload.** In FY 2002, the VAMC treated 33,519 unique veterans, a 22.5-percent increase over FY 2001. VAMC management attributed the increase in unique veterans treated to the continuing population growth in the area and the increasing number of veterans who are turning to VA for most or all of their medical care in order to use VA pharmacy benefits. The FY 2002 inpatient average daily census (ADC) was 42. For FY 2003, through May 2003, the ADC was 48. Outpatient workload totaled 227,261 patient visits in FY 2002 (a 26-percent increase over FY 2001) and 164,975 visits in FY 2003 through May 2003.

**Resources.** The VAMC's FY 2003 medical care budget is $93.4 million, a 26.6-percent increase over the FY 2002 budget of $73.8 million. FY 2003 staffing through May 2003, was 625.4 full-time equivalent employees (FTEE), including 43.1 physician and 182.1 nursing FTEE.

**Affiliations.** The VAMC is affiliated with the University of Arkansas for Medical Sciences at Little Rock and supports an average of two positions in the family practice residency program. The VAMC also supports nurse-training affiliations with the University of Arkansas, Northwest Arkansas Community College, Northwest Technical Institute, and the Har-Ber School of Nursing.

## Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

**Scope.** We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of

monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered VAMC operations for FY 2002 and FY 2003 through May 2003, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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

| | |
|---|---|
| Community Residential Care Program | Inventory management |
| Controlled substances accountability | Laboratory security |
| Employee quarters | Medical Care Collections Fund (MCCF) |
| Engineering equipment accountability | Nursing home contracts |
| Enrollment and resource utilization | Part-time physician time and attendance |
| Environment of care | Pharmacy security |
| Government Purchase Card Program | QM |
| IT security | Service contracts |

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–6). We did not make any recommendations but suggested improvements for the latter activities. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and VAMC management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to all employees and 112 responded. We also interviewed 30 patients during the review. We discussed the survey and interview results with the VAMC Director.

During the review, we also presented 4 fraud and integrity awareness briefings that were attended by 212 VAMC employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

# Results of Review

## Organizational Strengths

**The QM Program Was Comprehensive and Provided Effective Oversight.** The VAMC had an effective QM program to monitor the quality of care through use of national and local performance measures, patient safety data, and utilization review information. Senior managers implemented improvement actions based on collected, analyzed, and trended data. The program included an effective peer review process and used performance measures in the reprivileging of health care providers. QM specialists tracked, analyzed, and trended mortality and morbidity rates by individual providers. The executive management team supported the QM program.

**The Government Purchase Card Program Was Effectively Managed.** The VAMC had established effective procedures and controls to ensure that purchases were appropriate and were meeting the financial and administrative requirements of the Government Purchase Card Program. The Purchase Card Coordinator actively monitored all aspects of the Purchase Card Program. Cardholder, approving official, and coordinator responsibilities were properly separated. Purchases did not exceed warrant authority thresholds, and purchase cards were not used for unauthorized purposes, based on tests made. Purchase card approvals and reconciliations met Veterans Health Administration (VHA) timeliness standards.

**Information Technology Security Was Generally Effective.** The VAMC had adequate IT security to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for computer rooms and equipment was adequate, critical data was regularly backed up and properly stored off-site, contingency and security plans were current and complete, and annual computer security awareness training was provided as required.

**The Medical Care Collections Fund Program Was Well Managed.** VAMC management had established effective procedures to identify veterans with insurance and verify insurance coverage. Under the MCCF Program, VA may recover from health insurance companies the cost of treating certain veterans who have insurance. Bills submitted to insurance companies were timely and included correct procedure and diagnostic codes. Follow-up on outstanding bills over 90-days old was aggressive.

# Opportunities for Improvement

## Supply Inventory Management – Excess Medical and Engineering Inventories Needed To Be Reduced and Controls Improved

**Conditions Needing Improvement.** The VAMC needed to reduce excess inventories of medical and engineering supplies and make better use of automated controls to more effectively manage supply inventories. VHA policy establishes a 30-day stock level goal and mandates that medical facilities use VA's Generic Inventory Package (GIP) to manage medical and engineering inventory. The GIP automated inventory control system assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand.

Medical Supplies. Although Supply, Processing, and Distribution (SPD) Section staff used the GIP to manage medical supplies, the inventory exceeded the 30-day standard. As of May 2003, the SPD inventory consisted of 915 items with a stated value of $131,723. To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 medical supply items (value = $13,212). For 6 of the 20 sampled items, stock on hand exceeded 30-day supplies, with inventory levels ranging from 67 to 4,100 days of supply. For these six items, the estimated value of stock exceeding 30 days was $2,825, or 21.4 percent of the total value of the 20 sampled items. The excess stock occurred because SPD staff were not properly monitoring supply usage rates or adjusting GIP stock levels to meet the 30-day standard. By applying the 21.4 percent of excess stock for the sampled items to the entire SPD stock, we estimate that the value of excess stock was about $28,189 (21.4 percent x $131,723 stated value of stock).

Engineering Supplies. Engineering Service did not use the GIP or any other formal method to manage the engineering supply inventory. To test the reasonableness of stock levels, we reviewed a judgment sample of 10 high-use engineering supply items (value = $2,161). Because Engineering Service did not use the GIP, we asked service staff to estimate usage rates for the 10 items. For eight of the sampled items, stock on hand exceeded 30-day supplies, with inventory levels ranging from 40 to 497 days of supply (value = $1,317). For engineering supply items with current and recurring use, the GIP can be an effective inventory management tool and should be implemented in accordance with VHA guidance. Without inventory records, we could not estimate the value of all engineering supplies or the amount of inventory that exceeded current needs.

**Suggested Improvement Actions 1.** We suggested that the VISN Director ensure that the VAMC Director requires: (a) SPD to monitor supply usage rates and reduce excess medical supply inventory and (b) Engineering Service to conduct a wall-to-wall supply inventory, reduce excess engineering inventory, and implement the GIP for controlling engineering supplies.

The VISN and VAMC Directors agreed with our suggestions and reported that plans had been developed to monitor usage rates and reduce excess medical supply inventory on a monthly basis. In addition, by September 15, 2003, Acquisition and Materiel Management Service (A&MMS) will implement the GIP to control engineering supplies. The improvement plans are acceptable.

## Controlled Substances – Accountability and Access Deficiencies Needed To Be Corrected

**Conditions Needing Improvement.** We reviewed pharmacy security and controlled substances accountability to determine if controls were adequate to prevent the loss or diversion of drugs and to ensure that controlled substances were properly accounted for. We found five deficiencies in the areas of controlled substances accountability and access.

Controlled Substances Accountability. VAMC management needed to correct weaknesses in the controlled substances inspection procedures. VHA policy requires medical facilities to conduct monthly, unannounced inspections of all drug storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period from June 2002 through May 2003, and observed unannounced inspections of selected areas in which controlled substances were stored and dispensed. We identified three inspection deficiencies:

- Inspection procedures did not ensure that all controlled substances storage and dispensing locations were inspected every month. Controlled substances stored in an automated dispensing device located in the Mental Health Clinic were not included in the monthly, unannounced inspections.
- Inspection assignments and areas were not rotated as required. Three inspectors conducted inspections of the same areas 2 months consecutively, and one inspector conducted more than six inspections during a 12-month period.
- Two nurses were improperly appointed as controlled substances inspectors. VHA policy excludes pharmacists, nurses, physicians, and supply officials from being controlled substances inspectors.

Controlled Substances Access. VAMC management needed to ensure that all controlled substances were properly secured. VHA and VAMC policies require that controlled substances be stored in locked vaults or safes at all times. During our inspection of the pharmacy, we found that controlled substances were not properly secured in two areas:

- Mail-out controlled substances prescriptions awaiting pickup and delivery to the post office were placed in a bin in a pharmacy area where all pharmacy staff routinely had access.
- Containers of controlled substances that were delivered to the pharmacy by vendors were often left unattended in the pharmacy area before being properly secured.

**Suggested Improvement Actions 2.** We suggested that the VISN Director ensure that the VAMC Director implements controls to: (a) include all controlled substances storage and dispensing locations in monthly inspections, (b) rotate inspector assignments, (c) appoint inspectors who are not nurses or other excluded personnel, and (d) secure all controlled substances especially mail-out prescriptions and delivered drugs for pharmacy stock.

The VISN and VAMC Directors agreed with our suggestions and reported that as of June 24, 2003, all areas with controlled substances were included in the monthly inspections and they will comply with rotation of appropriate inspectors. A pharmacy vault is being designed to secure

mail-out prescriptions and delivered drugs from stock. The implementation actions are acceptable.

## Service Contracts – Contract Awards Needed To Be Better Documented

**Condition Needing Improvement.** VAMC contracting officers needed to improve the documentation of the contract award process. Contract files for competitive contracts should include documentation supporting contractor selection and the reasonableness of prices. Files for noncompetitive contracts should also include sufficient information to support the reasonableness of prices, as well as price negotiation memorandums (PNM) that document the negotiation process. In addition, for noncompetitive contracts over $500,000, the contracting officer must obtain legal and technical reviews from VHA.

To determine if the VAMC's contract administration and negotiation procedures were effective, we reviewed files for 10 service contracts, 3 competitive and 7 noncompetitive. Two of the 10 contract files did not contain required documentation. One file for a competitive contract did not contain sufficient documentation to support the reasonableness of contract prices, and one file for a noncompetitive contract valued at $2,250,000 was missing the required PNM and documentation of a legal and technical review. These problems occurred because contracting staff did not regularly review contract files to ensure that the contract award process was properly documented.

**Suggested Improvement Actions 3.** We suggested that the VISN Director ensure that the VAMC Director requires contracting officers to properly document the reasonableness of prices and obtain documentation of VHA legal and technical reviews.

The VISN and VAMC Directors agreed with our suggestion, and stated that A&MMS will consistently document legal and technical reviews and reasonableness of prices. The implementation actions are acceptable.

## Laboratory Security – Access Needed To Be Restricted to Authorized Personnel

**Conditions Needing Improvement.** Physical security deficiencies in the Clinical Laboratory needed correction. Unrestricted access to the laboratory through the blood draw room was possible. The laboratory did not keep logs to record entries by visitors, maintenance workers, or others needing one-time or occasional entry.

**Suggested Improvement Actions 4.** We suggested that the VISN Director ensure that the VAMC Director implements controls to: (a) restrict traffic between the blood draw room and the laboratory and (b) institute sign-in procedures in the Clinical Laboratory.

The VISN and VAMC Directors agreed with our suggestions and developed signage and sign-in procedures while we were on site. The implementation actions are acceptable.

**Appendix A**

# VISN 16 Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** August 25, 2003

**From:** Network Director (10N16), South Central VA Health Care Network (VISN 16)

**Subj:** Draft Report: Combined Assessment Program Review, Fayetteville VA Medical Center, AR, and (Project No. 2003-01855-HI-0229)

**To:** Director (54DA), Dallas Regional Office of Healthcare Inspections

**Thru:** Management Review and Administration (105E)

1. The South Central VA Health Care Network (VISN 16) has reviewed the subject Combined Assessment Program Review, Fayetteville VA Medical Center, AR.

2. The South Central VA Health Care Network concurs with the Suggested Improvement Actions contained in the subject Combined Assessment Program Review, Fayetteville VA Medical Center, AR.

3. The VA Medical Center Fayetteville, AR, Implementation Plan and Actions Taken have been reviewed, and the South Central VA Health Care Network concurs with the Implementation Plan and Actions Taken.

4. An electronic copy of the medical center Implementation Plan/Actions Taken and the medical center Director's memorandum to the Network Director are being forwarded for your review.

5. If you have any questions regarding the Implementation Plan/Actions Taken, please contact Janet McCumpsey, Executive Assistant to the Director, VAMC Fayetteville, AR, at (479) 587-5916.

*Signed by Albert Archie, Executive Assistant to the Network Director, on behalf of*
Robert Lynch, M.D.

Attachments

**Appendix B**

# Medical Center Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** August 21, 2003

**From:** Medical Center Director (564/00)

**Subj:** Draft Report: Combined Assessment Program Review, Fayetteville VA Medical Center, AR (Project No.2003-01855-HI-0229)

**To:** Director, Veterans Integrated Service Network 16 (10N16)

1. After careful review of the attached draft report, VAMC Fayetteville, Arkansas concurs with the suggested improvements.
2. Also attached is the Action Plan.
3. Should you need additional information please call Janet McCumpsey at 479-587-5916.

s//Michael R. Winn//

MICHAEL R. WINN

**Appendix B**

## Director's Comments to Office of Inspector General's Report

**Draft Report - Combined Assessment Program Review**
**Fayetteville VA Medical Center, Fayetteville, Arkansas**
**(Project No. 2003-018555-HI-0229)**

## Implementation Plan/Actions Taken OIG Suggested Improvements

**Status Update August 20, 2003**

**Suggested Improvement Action(s): 1.** We suggest that the VISN Director ensure that the VAMC Director requires:

(a) SPD to monitor supply usage rates and reduce excess medical supply inventory.

**CONCUR**

**ACTION**: SPD will monitor supply usage and reduce excess medical supply inventory by reviewing the stock status reports and taking prudent actions on a monthly basis.

(b) Engineering Service to conduct a wall-to-wall supply inventory, reduce excess engineering inventory, and implement GIP for controlled engineering supplies.

**CONCUR**

**ACTION**: A&MM Service will implement GIP for controlling engineering supplies by September 15, 2003. A&MMS will also monitor usage and reduce excess engineering supplies monthly.

**Suggested Improvement Action(s): 2.** We suggest that the VISN Director ensure that the VAMC Director implements controls to:

(a) Include all controlled substances storage and dispensing locations in monthly inspections.

**CONCUR**

**ACTION**: The ADDS machine was added 6/24/03. All others were previously included.

(b) Rotate inspector assignments.

**CONCUR**

**ACTION**: Will comply with rotating assignments every six (6) months and no inspector will inspect an area two months consecutively.

(c) Appoint inspectors who are not nurses or other excluded personnel.

**CONCUR**

**ACTION**: All RNs were removed 6/24/03 and replaced with appropriate personnel.

(d) Secure all controlled substances especially mail-out prescriptions and delivered drugs from pharmacy stock.

**CONCUR**

**ACTION**: Pharmacy vault is being designed and will be installed. Chief, Pharmacy Service has been instructed to comply with suggestions. Drug inspections will monitor for compliance.

**Suggested Improvement Action(s): 3.** We suggest that the VISN Director ensure that the VAMC Director requires contracting officers to properly document the reasonableness of prices and obtain documentation of VHA legal and technical reviews:

**CONCUR**

**ACTION**: A&MMS will consistently document the reasonableness of prices and obtain documentation of VHA legal and technical reviews when required.

**Suggested Improvement Action(s): 4.** We suggest the VISN Director ensure that the VAMC Director implements controls to:

(a) Post restrictive signage between the blood draw room and the laboratory.

**CONCUR**

**ACTION**: Signs were posted 6/25/03.

(b) Institute sign-in procedures in the clinical laboratory.

**CONCUR**

**ACTION**: Sign-in sheet was implemented 6/25/03.

s//Michael R. Winn//

**MICHAEL R. WINN**
**Medical Center Director**

**Appendix C**

# Monetary Benefits in Accordance with IG Act Amendments

**Report Title:** Combined Assessment Program Review of the VA Medical Center Fayetteville, Arkansas

**Report Number:** 03-01855-179

| Recommendation | Explanation of Benefit | Better Use of Funds |
|---|---|---|
| Suggestion | Better use of funds by reducing excess medical supply inventory. | $28,189 |

**Appendix D**

# Report Distribution

## VA Distribution

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VHA Chief Information Officer (19)
Director, Veterans Integrated Service Network (10N16)
Director, VA Medical Center (564/00)
Chief Quality and Performance Officer (10Q)

## Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office
U.S. Senate: Blanche Lincoln, Mark Pryor
U.S. House of Representatives: Marion Berry, John Boozman, Mike Ross
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives

Subcommittee on National Security, Emerging Threats, and International Relations
Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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