Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi

Report No. 03-02446-23

November 13, 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

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi (the facility) during the week of September 8-12, 2003. The purpose of the review was to evaluate selected medical center operations focusing on patient care administration, quality management (QM), and financial and administrative management controls. During the review, we also provided fraud and integrity awareness training to 145 medical center employees.

Results of Review

Generally, the facility was clean and in good repair. The QM program was operating satisfactorily, laboratory security was sufficient, and Nursing Home Care Unit (NHCU) services reviewed were adequate. Internal controls were operating effectively for part-time physician time and attendance, the Government Purchase Card Program, and patient waiting times. We recommended the Veterans Integrated Service Network (VISN) Director require the Medical Center Director to improve:

- Management controls over controlled substances inspections.
- Automated information systems (AIS) security.
- Administration of contracts for special transportation.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 7 – 12 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed. This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

(*Original signed by:)*

RICHARD J. GRIFFIN
Inspector General

Introduction

Facility Profile

Organization. The G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community-based clinics located in Hattiesburg, Meridian, Greenville, Kosciusko, Natchez, and Meadville. The facility is part of VISN 16 and serves a veteran population of about 137,000 in a primary service area that includes 49 Mississippi counties and Louisiana parishes.

Programs. The facility provides medical, surgical, mental health, and geriatric care, as well as sleep studies, hemodialysis, radiation therapy, post-traumatic stress disorder, readjustment counseling, and rehabilitation services. The facility has 136 acute hospital beds, 27 residential care program beds, and 120 nursing home care unit (NHCU) beds and operates several regional referral and treatment programs.

Affiliations and Research. The facility is affiliated with the University of Mississippi School of Medicine and supports 72 medical resident positions in 20 training programs. In Fiscal Year (FY) 2002, the facility's research program had 82 projects and a budget of $2 million. Important areas of research include Alzheimer's Disease, schizophrenia, and hypertension.

Resources. In FY 2002, medical care expenditures totaled $166,138,177. The FY 2003 medical care budget was $173,421,141. FY 2002 staffing totaled 1,436 full-time equivalent employees (FTEE), including 72 physician and 479 nurse FTEE.

Workload. In FY 2002, the facility treated 39,936 unique patients. The facility provided 36,334 days of care in the hospital (not including residential care) and 41,744 inpatient days of care in the NHCU. The inpatient care workload totaled 5,265 discharges, and the average daily census, including nursing home patients, was 214. The outpatient workload was 263,823 visits.

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 healthcare services. The objectives of the CAP review 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 general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. 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 facility operations from October 1, 2000, through September 11, 2003, and was done 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 selected aspects of the following activities and programs:

AIS Security	Laboratory Security
Contract Award and Administration	NHCU
Controlled Substances Security	Part-Time Physician Time and Attendance
Environment of Care	Patient Waiting Times
Government Purchase Card Program	QM

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. We sent electronic survey questionnaires to medical center employees, 314 of whom responded. We also interviewed 30 patients during our review. The surveys indicated high levels of patient satisfaction and moderately high levels of employee satisfaction and did not disclose any significant issues. We provided the survey results to medical center managers.

During the review, we also presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 145 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Controlled Substances - Inspection Procedures Needed To Be Improved

Conditions Needing Improvement. The controlled substances monthly inspection program needed improvement. The following conditions required management attention:

- Controlled substances inspections were not random or unannounced as required by VA policy. Medical center policy required that inspections be scheduled between 9 a.m. and 2:30 p.m. during the first 5 days of the month for most medical center locations and on Monday, Wednesday, or Friday in the inpatient pharmacy. Our review showed that the inspections were predictable because the majority of the inspections were conducted within the first 10 days of the month.

- Inspectors did not inspect all locations containing controlled substances. From August 1, 2002, to July 31, 2003, inspectors did not perform 36 (13 percent) of the 276 required monthly inspections. Inspectors never inspected controlled substances stored in Research Service.

- Controlled substances inspectors did not review drug expiration dates during the monthly inspections. We observed unannounced inspections of the inpatient and outpatient pharmacy vaults and found that inspectors did not review drug expiration dates. We had the two inspectors recheck the vault areas and they found six expired drugs. At our request, the inspectors checked 10 wards and found expired drugs on 3 of the wards. All expired drugs were immediately removed. We interviewed six additional inspectors who told us that they were not aware that they should check for expired drugs during the monthly inspections.

Recommended Improvement Action(s) 1. We recommended that the VISN Director ensure that the Medical Center Director implements procedures to:

a. Require that controlled substances inspections are random and unannounced.
b. Inspect all locations containing controlled substances each month.
c. Review drug expiration dates during monthly unannounced inspections and remove expired drugs from inventory.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needed Improvement

Conditions Needing Improvement. The following AIS security conditions required management attention:

- Certain Veterans Health Information Systems and Technology Architecture (VISTA) user accounts needed to be terminated. At our request, the Chief Information Officer and the Information Security Officer reviewed 48 user accounts not accessed in more than 90 days from the date of last sign on or not accessed more than 30 days from the date the account was established. The VISTA system manager reported to us that 22 individuals still needed access and that 26 user accounts were terminated during the CAP review.

- Human Resources Management employees had not requested background investigations for three IRM system managers. Background investigations for the three employees were requested during the CAP review.

Recommended Improvement Action(s) 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that:

a. VISTA user accounts are terminated when access is no longer needed.
b. Required background investigations are completed for all key staff.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Contracts – Invoices for Transportation Services Were Not Properly Verified Before Payment

Conditions Needing Improvement. The Contracting Officer's Technical Representative (COTR) certified ambulance and taxi invoices for payment without verifying that the invoices complied with contract terms. We estimated that the medical center overpaid about $107,300 for transportation services rendered. We also found that the medical center provided transportation services for wheelchair patients by ambulance, which was not cost-effective.

- An ambulance contractor billed the medical center about $1.39 million during the period October 1, 2001, through August 26, 2003. The contract terms stated that the contractor should bill the medical center a base rate of $110 for non-emergency, or $150 for emergency transportation services within a 20-mile radius of the medical center. Rates for mileage exceeding the initial 20-mile radius were to be charged at $2.25 per mile for non-emergency services, and $3.25 per mile for emergency services. Our review showed that the contractor

actually billed for the base rate and total number of miles, instead of the miles that exceeded the 20 miles included in the base rate. In July 2003, there were 225 trips billed at a total of $66,405. We reviewed 32 of these trips totaling $7,789 and found that the medical center was over billed by $517 (6.6 percent) for 14 trips. Projecting the 6.6 percent error rate found in the July invoices to the $1.39 million paid through August 2003, we estimated that the medical center could have overpaid the contractor as much as $92,000 since October 1, 2001. Assuming the same rate of expenditure ($60,000 per month) during the remaining 13 months of the contract, we estimate that the medical center could save an additional $51,500 by ensuring that contractor invoices comply with the terms of the contract.

- A taxi contractor billed the medical center about $146,000 for services provided from October 1, 2000, through August 26, 2003, including $113,200 for trips between the medical center and veterans' residences, and $32,800 to local airport, bus station, and University hospital destinations specified in the contract. The contract terms specified that the medical center would pay $1.65 per mile, as determined by the latest Rand McNally Standard Mileage Guide. We found that invoices for trips to local destinations specified in the contract were properly billed. Of the $113,200 in trips to veterans' residences, $9,600 was billed for one dialysis patient. We reviewed all charges for this patient and found that the medical center was over billed about $4,500 for these trips due to excessive mileage claims. For the remaining $103,600 in trips to veterans' residences, we sampled 31 trips totaling $1,100 made between May 26, 2003, and July 30, 2003, and found that the medical center was over billed $110 (10 percent) by the contractor, because the contractor billed the medical center for mileage that exceeded the Rand McNally Standard Mileage Guide. Projecting the 10 percent error rate to the $103,600 paid through August 2003, we estimate that the medical center could have overpaid the contractor as much as $10,400. We did not estimate a future cost avoidance because this contract was scheduled to end on September 30, 2003.

- All wheelchair patients were transported by ambulance, even though all did not require this level of transportation service. The medical center did not have a contract to transport wheelchair patients. At our request, Acquisition and Materiel Management Service (A&MMS) employees surveyed local vendors and identified two that provided wheelchair patient transportation services. According to A&MMS, both vendors offered wheelchair transportation services at rates significantly lower than ambulance service costs.

Recommended Improvement Action(s) 3. We recommended that the VISN Director ensure that the Medical Center Director requires that:

a. Transportation invoices are verified for compliance with contract terms before payment.
b. All invoices from the ambulance and taxi service contractors are reviewed to determine the amount of overpayments and appropriate collection action is taken.
c. A&MMS employees initiate actions to obtain cost effective transportation services for wheelchair patients.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. A&MMS contracting employees attempted to collect the overpayment from the ambulance service contractor.

However, because of the ambiguities in the contract, the VA Regional Counsel advised medical center management not to proceed with back billing the contractor. A&MMS employees amended the ambulance contract on October 1, 2003, to remove the ambiguities. The Regional Counsel also advised medical center management not to back bill the taxi contractor because of a verbal agreement between the COTR and contractor regarding the specific veteran's trips. A&MMS employees amended the new taxi contract on October 1, 2003, to remove ambiguities in the contract regarding mileage changes. Medical center management actions were responsive to our recommendations and we consider the issue resolved. We will follow up on the planned actions until they are completed.

Appendix A

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 20, 2003

From: Director, G.V. (Sonny) Montgomery VA Medical Center (586/00)

Subject: **Response to the G.V. (Sonny) Montgomery VA Medical Center CAP Review # 2003-02446-HI-0309**

To: Office of Inspector General

The recommendations from the Combined Assessment Program review of September 2003, have been reviewed and we concur with your findings. Our response is attached.

Richard J. Baltz

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

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director implements procedures to:

a. Require that controlled substances inspections are random and unannounced.
b. Inspect all locations containing controlled substances each month.
c. Review drug expiration dates during monthly unannounced inspections and remove expired drugs from inventory.

Concur **Target Completion Date:** October 31, 2003

Jackson, VAMC submits the following response dated 10/20/03.

a. Pen and ink change was made to local policy during CAP review to remove specified time and day for inspections. Random process was implemented during October narcotics inspections. Inspectors were trained to conduct unannounced inspections. The Control Substances Coordinator will monitor with spot checks to ensure compliance.

b. Pen and ink change to local policy includes all locations to include eye clinic and endoscopy suite. Controlled Substances Coordinator to routinely obtain updated lists of areas with controlled substances prior to initiating monthly inspections.

c. Although VHA Handbook 1108.2 does not require review of expiration dates during monthly narcotics inspections, we concur with the logic of this recommendation. The following actions have been taken: Inspectors were instructed to inspect expiration dates. Inspector checklist was revised to require review for expiration dates. Pharmacy ADPAC and Inpatient Supervisor are testing the expiration date tracking option in the Controlled Substances software.

Of note, we are rewriting our policy for compliance with the new directive and anticipate full implementation by December 30, 2003.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. VISTA user accounts are terminated when access is no longer needed.
b. Required background investigations are completed for all key staff.

Concur **Target Completion Date:** Date: (a.) October 31, 2003 (b.) 9 -11 months per OPM

Jackson, VAMC submits the following response dated 10/20/03.

a. The following plan of corrective action has been implemented to ensure compliance:

(1.) Quarterly user menu reviews by all Services.

(2.) Use of an automated routine to deactivate users after 90 consecutive days of account inactivity.

(3.) Periodic fileman queries conducted by Assistant Chief of IRM to identify accounts requiring termination.

(4.) IRM signing off on employees clearing station forms so that their access can be terminated.

(5.) IRM verifying termination against a monthly employee gains and losses report generated by Human Resources Management Service (HRMS).

(6.) The Information Security Officer (ISO) will perform quarterly audits of employee gains and losses against IRM termination reports.

b. Background investigations on the three staff members identified during the CAP review were initiated on 9/10/03. Per OPM, the security clearence may take 9-11 months to compete. The following process is curently in place for all high-security staff background investigations:

(1) As identified positions are filled, securities are initiated upon establishment of an Official Personnel File (OPF) or upon receipt of the OPF from another agency/VA facility.

(2) OPFs are duplicated and sent with forms 0237 and 2280 to VA Headquarters, security section.

(3) Central Office then identifies the appropriate forms to be completed and forwards the forms packets, and duplicate OPF to our security POC - Ms Ethel Brooks.

(4) Upon receipt of the forms, a memo is generated to the identified individual about filling out the packet, coming to HRMS for finger printing and duplicate set of the forms are made as backup.

(5) Packet will be sent to the employee with instructions on completing the forms, how to arrange for finger printing, and the deadline for returing the completed packet to HRMS.

(6) The completed forms and finger prints are then sent to Headquarters with a cover memorandum.

(7) Individual names of clearances in process are then tracked using an excel spreadsheet containing the status of the information.

(8) Quarterly checks by HRMS with Headquarters via electronic email will be done to verify the status of clearances.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that:

a. Transportation invoices are verified for compliance with contract terms before payment.
b. All invoices from the ambulance and taxi service contractors are reviewed to determine the amount of overpayments and appropriate collection action is taken.
c. A&MMS employees initiate actions to obtain cost effective transportation services for wheelchair patients.

Concur **Target Completion Date:** October 1, 2003

Jackson, VAMC submits the following response dated 10/20/03.

a. Compliance will be monitored for all contracts by the assigned COTR with documentation. Specifically, the Ambulance and Taxi contract invoices will have 100% review by the COTR with random 10% review by the appropriate Service Chief.

Effective October 1, 2003 the ambulance contract was amended to read:

The following changes are hereby made to Contract V586P-3806 effective October 1, 2003 through September 30, 2004:

1. Delete all references to “Any trip within city limits of Jackson, MS.”

2. The mileage threshold for a one-way trip will be 20 miles from the VA Medical Center.

3. Mileage beyond the 20 miles will be paid, per mile, as listed by the Rand McNally Standard Mileage Guide.

Effective October 1, 2003, the Taxi contract was amended to read:

In accordance with FAR 52.212-4, Contract Terms and Conditions-Commercial Items (FEB 2002) © Changes Contract No V586P-3975 is hereby modified, to add the following flat rate trips.

VA area	$7.50/trip
Downtown area	$10.00/trip
Airport area (Pearl)	$18.00/trip
CMMC area (South)	$18.00/trip
Zoo area	$12.00/trip
Brandon area	$25.00/trip
Florence area	$25.00/trip
Clinton area	$20.00/trip
Richland area	$18.00/trip
North Park area	$15.00/trip
Presidential Hills area	$18.00/trip
St. Dominics Hospital	$8.00/trip
Extended Stay America	$11.00/trip

b. A meeting was held with the contractor for the Ambulance service on September 30, 2003 at 0900. Agreement could not be reached as review of the contract revealed ambiguity as to “Mileage Threshold 20 miles” and “within the city limits”. The contractor was billing based upon the “city limits”. The amendment as stated above clarified the issue and compliance with the amendment is being monitored. Because of the ambiguity of the contract, Regional Counsel did not advise us to proceed with “back billing”. It was further recommended that no "back billing" related to the Taxi contract be done. Based on information from the COTR and the Contractor, there was a verbal agreement related to the specific veteran's trips found to be out of compliance with the contract. It is viewed as unethical at this point to deny that agreement. The new flat rates established in the amendment to the contract resolves that issue for future trips. Verbal contracts will not be accepted. (recommend closure of this action item)

c. When the new solicitation is prepared for FY 2005 ambulance requirements, wheelchair transportation will be included in the new solicitation.

Appendix B

VISN 16 Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 22, 2003

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

Subject: **Response to the G.V. (Sonny) Montgomery VA Medical Center CAP Review # 2003-02446-HI-0309**

To: Office of Inspector General (53)

We have reviewed the subject report and concur with the recommendations and responses.

Robert Lynch, M.D.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3a	Verify that future invoices comply with terms of the contracts.	$51,500.00
	Total	$51,500.00

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgements	James R. Hudson, Director, Atlanta Office of Audit Floyd Dembo, Audit Manager Leon Roberts, Audit Team Leader Bertha Clarke, Healthcare Inspections Team Leader Tom Godeaux Harvey Hittner Judy Lawhead Tina Mitchell Steve Wiggins

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