Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Tuscaloosa, Alabama

Report No. 04-00931-166 **July 15, 2004**

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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Contents

Executive Summary

Introduction

During the week of February 9-13, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center Tuscaloosa, Alabama, which is part of Veterans Integrated Service Network (VISN) 7. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 3 fraud and integrity awareness briefings to 223 employees.

Results of Review

This CAP review focused on ten areas. As indicated below, there were no concerns identified in the following six areas:

- Environment of Care
- Follow up of Previous CAP Report
- Government Purchase Card Program
- Patient Care Administration
- Quality Management
- Supply Inventory Management

Based on our review of these six areas, the following organizational strengths were identified:

- Implementation of the recommendations and suggestions contained in our August 2000 CAP report of the facility.
- Monitoring of OIG CAP review reports.
- Patient Identification System helped prevent errors.

To improve operations, we made recommendations in the following areas:

- Administration of the contract for ambulance services.
- Automated information systems (AIS) security.
- Acquisitions of scooter/wheelchair repairs and installations of vehicle lifts.
- Evaluations of Pharmacy Service usage levels.

VISN 7 Director and Acting Medical Center Director Comments

The VISN 7 Director and the Acting Medical Center Director agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 9 – 14 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 Mr. James R. Hudson, Director, Atlanta Audit Operations Division.

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

Introduction

Medical Center Profile

Organization. VA Medical Center Tuscaloosa provides primary care, long-term health care, and mental health care services to eligible veterans in VISN 7. The medical center serves a veteran population of about 34,000 in a primary service area that includes 13 counties in western Alabama.

Programs. The medical center provides medical, long-term, mental health, and geriatric services. The medical center has 146 hospital beds and 178 Nursing Home Care Unit (NHCU) beds.

Affiliations and Research. The medical center is affiliated with the University of Alabama Colleges of Medicine, Dentistry, Nursing, Pharmacy, and Allied Health and supports two medical resident positions in one training program. In fiscal year (FY) 2003, the medical center research program had 18 projects and a budget of $688,094. Important areas of research include the clinical treatment of depression, post traumatic stress disorder, bipolar, schizophrenia, dual diagnosis, and the prevention of prostate cancer. The medical center also has a sharing agreement with the 81st Regional Support Command in Birmingham, Alabama.

Resources. In FY 2003 medical care expenditures totaled $64.7 million. The anticipated FY 2004 medical care budget is $75.2 million. FY 2003 staffing totaled 811 full-time equivalent employees (FTE), including 23 physician and 122 nursing FTE.

Workload. In FY 2003, the medical center treated 14,797 unique patients, and provided 33,013 inpatient days of care in the hospital and 61,861 inpatient days of care in the NHCU. The inpatient care workload included 1,019 discharges, and the average daily census was 90 for the hospital and 169 for the NHCU. The outpatient care workload was 146,479 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that the Nation's veterans receive high quality health 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 integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity 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. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or 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. We also followed up on the recommendations and suggestions included in our previous CAP report of the facility *(Combined Assessment Program Review VA Medical Center Tuscaloosa, Alabama, Report No. 00-02003-108, dated August 18, 2000)*. The review covered facility operations for FY 2003 and FY 2004 through February 13, 2004, 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:

Automated Information Systems	Government Purchase Card Program
Contract Administration	Patient Care Administration
Controlled Substances	Prosthetics
Environment of Care	Quality Management
Follow up of Previous CAP Report	Supply Inventory Management

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. The surveys indicated high levels of patient satisfaction and moderately high levels of employee satisfaction, and did not disclose any significant issues. The survey results were provided to medical center management.

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 – 7). For these activities we make recommendations for improvements. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During the review, we also provided 3 fraud and integrity awareness briefings to 223 medical center employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Results of Review

Organizational Strengths

Monitoring of OIG CAP Review Reports

Management Monitored OIG CAP Review Reports Of Other Medical Facilities to Improve Operations. In addition to implementing the recommendations and suggestions in our previous VA Medical Center Tuscaloosa CAP report, medical center management systematically reviewed the OIG CAP reports of other medical facilities with their service chiefs to ensure that local policies and procedures complied with Veterans Health Administration (VHA) policies. As a result, management took corrective actions or developed action plans for the following areas:

- Environment of Care
- Credentialing, Privileging, and Background Investigations of Independent Practitioners
- Community Nursing Home Program
- Veterans' Eligibility Means Testing
- Supply Inventory Management
- Government Purchase Card Program

Patient Identification System

Inpatient Photographs Helped Prevent Medication Errors. Medical center staff integrated digital photographs of patients taking high-risk medications, such as insulin or heparin, with the Bar Code Medication Administration (BCMA) program and the Computerized Patient Record System (CPRS). When a nurse utilizes the BCMA program to administer high-risk medications to a patient, the computer screen displays a photograph of that patient. Medical center policy requires nurses to use three of four approved methods to validate medication correctness and the identity of the patient. The policy calls for scanning both the patient's armband and the medication, and having a nurse other than the medication nurse validate the medication dosage and identify the patient. In the past, only a nurse who knew the patient could verify the patient's identity. The digital photograph allows a nurse unfamiliar with the patient to verify the patient's identity. This BCMA/CPRS photograph system enhances patient safety by reducing the potential for medication errors.

Opportunities for Improvement

Contract Administration – Internal Controls for Ambulance Services Needed Improvement

Condition Needing Improvement. The medical center paid about $1.4 million to a vendor for ambulance services from October 2000 through December 2003, which included overpayments totaling about $88,500. According to the contract, the vendor was to be paid a base amount for each trip within the city limits of Tuscaloosa and an additional mileage charge for each mile traveled outside of the city limits. Our review of the contract and a judgment sample of 30 trips found that:

- The vendor incorrectly charged for mileage within the city limits. A sample of 30 trips with mileage charges totaling $11,080 showed that 613 (23.5 percent) of the 2,607 miles charged were within the city limits, resulting in overcharges totaling $2,604 (23.5 percent). Based on these results, we estimate that the medical center overpaid the vendor about $88,500 (23.5 percent of the $376,800 paid for mileage), since the inception of the contract. Assuming the same rate of expenditure for the remaining 21 months, the medical center could save as much as $47,649[1] by only paying contract rates for the remainder of the contract (through September 30, 2005).

- The overpayments occurred because the Contracting Officer's Technical Representatives (COTRs) did not properly monitor the contract, nor did the COTRs verify that the vendor's invoices complied with contract terms prior to certifying the invoices for payment. While the contract stated that the Rand McNally Standard Mileage Guide would be used to determine mileage, the guide only showed mileage from the Tuscaloosa city center to another city center, rather than mileage traveled between the Tuscaloosa city limits and the destination. Further, the COTRs did not know the location of the Tuscaloosa city limits in order to determine the correct mileage.

The VISN 7 Network Contracting Activity (NCA) awarded the ambulance contract; therefore, we made recommendations directly to the VISN 7 Director to correct the contracting matters.

Recommended Improvement Action(s) 1. The VISN 7 Director should require that:

a. The VISN 7 NCA staff develops a verifiable payment system with the ambulance services vendor.

[1] The future cost savings was computed by dividing the $88,500 total expenditures for mileage by 39 months to arrive at the average overpayment of $2,269 per month. We then multiplied the average monthly overpayment ($2,269) times the 21 remaining months to arrive at the future cost savings of $47,649.

b. The VISN 7 NCA staff reviews all contracts the ambulance services vendor has with VA Medical Center Tuscaloosa and other VISN 7 medical centers to identify and collect overpayments.

The VISN 7 Director agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Recommended Improvement Action(s) 2. The VISN 7 Director should require that the Acting Medical Center Director ensures that the COTRs verify mileage prior to certification of invoices.

The VISN 7 Director and the Acting Medical Center Director agreed with the findings and recommendations, and the VISN 7 Director agreed with the Acting Medical Center Director's corrective action plan. The Acting 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

Condition Needing Improvement. Security of the medical center's automated information system (AIS) needed improvement. The following conditions needed management attention: the Veterans Health Information System and Technology Architecture (VISTA) contingency plan was not complete and AIS areas had signage identifying their locations.

- The VISTA contingency plan did not include the configurations for AIS hardware and software, detailed recovery procedures, identification of files requiring back up, labeling schemes for back-up tapes, and procedures regarding the medical center's VISTA Imaging System.
- Signage identifying entrances to areas containing sensitive information and automated systems posed a potential security risk.

Recommended Improvement Action(s) 3. The VISN 7 Director should require the Acting Medical Center Director to ensure that:

a. The VISTA contingency plan is updated to include the required items.

b. Signage identifying locations of sensitive information and automated systems is removed.

The VISN 7 Director and the Acting Medical Center Director agreed with the findings and recommendations, and the VISN 7 Director agreed with the Acting Medical Center Director's corrective action plan. The Acting Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Prosthetics – Prosthetics Service Contracting Needed Improvement

Condition Needing Improvement. During the 16-month period ending January 2004, Prosthetics Service purchasing agents made 824 purchases totaling over $645,000 from a vendor for setup, delivery, and repair services under a noncompetitive local Statement of Work (SOW). The SOW described the responsibilities of the vendor and provided for hourly labor rates and travel charges based upon the county of destination. VISN 7 staff indicated that other vendors within the state could have provided the same services. Therefore, the medical center may have obtained better prices had they solicited bids for these services.

In addition, the vendor was supposed to charge Federal Supply Schedule (FSS) contract prices for equipment and parts. Our review showed that the vendor was not always able to get items at FSS prices because he was not a distributor or the manufacturer would not sell to him at FSS contract prices. Furthermore, Prosthetics Service purchasing agents did not have the FSS contract price lists to verify whether the vendor charged the medical center FSS contract prices for equipment and parts. VISN 7 Prosthetics Service staff should provide items for setup and delivery when the vendor cannot obtain them at FSS prices.

The VISN 7 Prosthetics Manager supervises the Prosthetics Service staff at the medical center; therefore, we made recommendations directly to the VISN 7 Director to correct the prosthetics purchasing matters.

Recommended Improvement Action(s) 4. The VISN 7 Director should require that:

a. VISN 7 Prosthetic Service staff obtains needed prosthetic services competitively.

b. VISN 7 Prosthetics Service purchasing agents verify that VA is charged FSS prices prior to authorization of payment.

c. VISN 7 Prosthetics Service staff provides items for setup and delivery when the vendor cannot obtain them at FSS prices.

The VISN 7 Director agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Controlled Substances – Evaluation of Inventory Levels Needed Improvement

Condition Needing Improvement. Pharmacy Service had not fully implemented the Pharmaceutical Prime Vendor Inventory Management (PVIM) software to monitor the pharmacy stock, as required by VHA. During most of FY 2003, Pharmacy Service reordered controlled substances without using PVIM software. As of September 2003, Pharmacy Service commenced

manual reviews of the controlled substances inventories to establish minimum and maximum stock levels and determine optimum inventory levels. As of January 26, 2004, the combined controlled substances inventories of the outpatient and inpatient vaults totaled about $30,330 for about 150 line items. Our review of the controlled substances usage during the period January 1, 2003, through January 26, 2004, found that about 70 line items (47 percent) had excess stock totaling about $20,300 (67 percent).

Recommended Improvement Action(s) 5. The VISN 7 Director should require the Acting Medical Center Director to ensure that Pharmacy Service staff uses PVIM to evaluate stock levels of controlled substances.

The VISN 7 Director and the Acting Medical Center Director agreed with the findings and recommendations, and the VISN 7 Director agreed with the Acting Medical Center Director's corrective action plan. The Acting Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1a.	Recover overpayments to ambulance services vendor.	$88,500
1b.	Better use of funds by paying contract rates for the remainder of the contract (through September 30, 2005).	47,649
5	Better use of funds by reducing the stock level of controlled substances.	20,300
	Total	$156,449

Appendix B

VISN 7 Director's Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2004

From: Veterans Integrated Service Network Director (10N7)

Subject: **VA Medical Center Tuscaloosa, Alabama**

To: Director, Office of Inspector General, Office of Audit (52AT)

THRU: Director, Management Review Office (105B)

1. We have reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the Tuscaloosa VA Medical Center. We concur with the findings and recommendations. I also concur with comments and planned actions for each recommendation.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

(*original signed by:*)

LINDA F. WATSON

VISN 7 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 7 Director should require that:

a. The VISN 7 NCA staff develops a verifiable payment system with the ambulance service vendor.

b. The VISN 7 NCA staff reviews all contracts the ambulance service vendor has with Tuscaloosa and other VISN 7 medical centers to identify and collect actual overpayments.

Concur **Target Completion Date:** May 31, 2004

a. The VISN 7 NCA will hold another Post-Award Conference with the contractor and include the Contracting Officer Technical Representative (COTR) to ensure all parties understand the statement of work, billing process and pricing structure prior to certification of invoices. The additional Post-Award meeting will be held by May 31, 2004.

b. This vendor was awarded a contract for Birmingham and Tuscaloosa. The Contracting Officer and the COTR for Birmingham and Tuscaloosa are reviewing all invoices for the period October 2000 to present for services rendered. The vendor will be issued a Bill of Collection for any discrepancy. This review will be completed by May 31, 2004.

Recommended Improvement Action(s) 4. The VISN 7 Director should require that:

a. VISN 7 Prosthetic Service staff obtains needed prosthetic services competitively.

b. VISN 7 Prosthetics Service purchasing agents verify that VA is charged FSS prices prior to authorization of payment.

c. VISN 7 Prosthetics Service staff provides items for setup and delivery when the vendor cannot obtain them at FSS prices.

Concur **Target Completion Date:** Completed.

a. A VISN 7 Prosthetic Standard Operating Procedure (Repair of Home Medical Equipment, No. 11) was established and training was provided to complement already existing purchasing requirements to ensure compliance. Also, a list of vendors in the Tuscaloosa area has been provided to staff which is used for services. In addition, a FSS vendor listing has been provided to staff which identifies FSS sources.

b. Prosthetic Service purchasing agents are verifying that VA is charged FSS prices prior to authorizing the work to be performed by review of printed or internet costing documents and/or related contract costs.

c. Prosthetic Service purchasing agents are procuring through FSS Contract or Blanket Purchasing Agreement (BPA) items for setup and delivery when the vendor cannot obtain them.

Appendix C

Acting Medical Center Director's Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2004

From: Acting Medical Center Director (679/00)

Subject: **VA Medical Center Tuscaloosa, Alabama**

To: Network Director (10N)

1. I have reviewed the findings in the draft report and concur with the recommendations. Actions taken along with planned actions are listed.

2. If you have questions or need additional information, please let me know.

(original signed by:)

JOHN S. GOLDMAN

Acting Medical Center Director's Comments to Office of Inspector General's Report

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

OIG Recommendation(s)

Recommended Improvement Action(s) 2. The VISN 7 Director should require that the Acting Medical Center Director ensures that the COTRs verify mileage prior to certification of invoices.

Concur **Target Completion Date:** Complete.

The COTR and the Contracting Officer have communicated to ensure the complete and proper understanding of the terms of the contract. The COTR will verify mileage prior to certification of invoices. All processes are in place to ensure proper verification based on the contract.

Recommended Improvement Action(s) 3. The VISN 7 Director should require the Acting Medical Center Director to ensure that:

a. VISTA contingency plan is updated to include the required items.

b. Signage identifying locations of sensitive information and automated systems is removed.

Concur **Target Completion Date:** May 31, 2004

a. VISTA contingency plan will be updated to include all required items by May 31, 2004

b. Signage removed during review. Completed.

Recommended Improvement Action(s) 5. The VISN 7 Director should require the Acting Medical Center Director to ensure that Pharmacy Service staff uses PVIM to evaluate stock levels on pharmacy stock.

Concur **Target Completion Date:** November 10, 2004

TVAMC is using the Prime Vendor Inventory Management (PVIM) software to evaluate and set appropriate levels of pharmacy stock. We have completed implementation of the software for controlled substances and have modified our stock levels appropriately. Full implementation for all other pharmaceuticals has been interrupted by the national change in prime vendor company. It is dependent on the software supplied by the new prime vendor (McKesson) which begins May 10, 2004. Since inventory control and management is a fluid process and depends on changing usage data, full implementation cannot be completed with the new prime vendor software until we have enough order data generated to get reasonable evaluation and stock levels. Most published information suggests six (6) months is an adequate time period so we have set that time period for complete implementation. We are rapidly progressing with implementation for the highest volume of drugs ("A" items) establishing max/min levels based upon our specific usage data and adjusting inventory accordingly. We will have full implementation for all pharmaceuticals within six (6) months of the start date of the new prime vendor (November 10, 2004). An implementation plan has been developed to track progress.

Appendix D

OIG Contact and Staff Acknowledgements

OIG Contact	James Hudson, Director, Atlanta Audit Operations Division (404) 929-5921
Acknowledgements	Floyd Dembo, CGFM, Audit Manager (CAP Coordinator) Victoria Coates, Director, Atlanta Office of Healthcare Inspections Ann Batson, Audit Team Leader Bertha Clarke, Healthcare Inspections Team Leader George Boyer Harvey Hittner Judy Lawhead Darlene Perkins Leon Roberts

Appendix E

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