VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of
Mobile Medical Units

May 14, 2014
13-03213-152

ACRONYMS AND ABBREVIATIONS

CBOC	Community Based Outpatient Clinic
DSS	Decision Support System
FY	Fiscal Year
MMU	Mobile Medical Unit
OIG	Office of Inspector General
ORH	Office of Rural Health
RV	Recreational Vehicle
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Highlights: Audit of VHA's Mobile Medical Units

Why We Did This Audit

The House Committee on Appropriations requested the Office of Inspector General to conduct a review of VA's use of Mobile Medical Units (MMUs) to assess whether the Veterans Health Administration (VHA) is fully utilizing MMUs to provide health care access to veterans in rural areas.

What We Found

VHA lacks information about the operations of its MMUs and has not collected sufficient data to determine whether MMUs improved rural veterans' health care access. VHA lacks information on the number, locations, purpose, patient workloads, and MMU operating costs.

We determined VHA operated at least 47 MMUs in fiscal year 2013. Of these, 19 were funded by the Office of Rural Health (ORH) and the remaining 28 were funded by either a Veterans Integrated Service Network or medical facility. Medical facilities captured utilization and cost data in VHA's Decision Support System (DSS) for only 6 of the estimated 47 MMUs. If VHA consistently captured these data, it could compare MMU utilization and costs with other health care delivery approaches to ensure MMUs are providing efficient health care access to veterans in rural areas.

These weaknesses occurred because VHA did not designate specific program responsibility for MMU management, define a clear purpose for its MMUs, or establish policies and guidance for effective and efficient MMU operations.

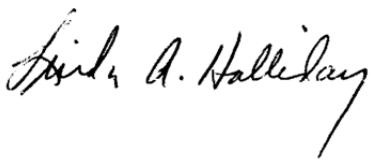
As a result of limited MMU data, we were unable to fully address the Committee's concerns. However, it is apparent that VHA cannot demonstrate whether the almost $29 million ORH spent, as well as unknown medical facility funding for MMUs, increased rural veterans' health care access and the extent to which MMUs can be mobilized to support its emergency preparedness mission.

What We Recommended

We recommended the Under Secretary for Health improve the oversight of MMUs by assessing their effect on rural veterans' health care access; establishing specific program responsibilities, policies, and guidance, including requirements to capture MMU data in DSS; and supporting emergency preparedness plans.

Agency Comments

The Under Secretary for Health concurred with our recommendations and provided an acceptable action plan. We will follow up on the implementation of the corrective actions.



LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

We conducted this audit to determine whether the Veterans Health Administration (VHA) is fully utilizing mobile medical units (MMUs) to provide improved health care access to veterans in rural areas.

What Was Asked of the OIG

The U.S. House of Representatives Committee on Appropriations requested the Office of Inspector General (OIG) to conduct a review of VA's use of MMUs. The Committee was interested in whether VHA is fully utilizing MMUs to provide improved health care access to veterans in rural areas. We were asked to determine the following:

- The average monthly usage per MMU and the optimum use of an MMU
- Staffing per MMU and to what extent staffing shortages led to non-use of the MMU
- Average monthly cost per MMU
- Any available comparisons between the costs of health care provided through MMUs with the cost of health care provided through conventional VA facilities
- Total amount budgeted and actual costs for MMUs in FY 2012
- VA's long-term plans for the MMU pilot program

Mobile Medical Units

In 1988, Congress authorized $5 million for each of two fiscal years, through the Veterans' Benefits and Services Act, for VHA to conduct an MMU demonstration project. The project's purpose was to increase rural veterans' access to VA health care services and evaluate the feasibility of using MMUs. A case study was published in 1999 of the six MMUs funded.

This study found that while there was an increased use of VHA's outpatient services that could be attributed to the MMUs, providing health care through MMUs was expensive.[1]

Additional Information

The following appendixes provide additional information:

- Appendix A provides pertinent background information.
- Appendix B provides details on our scope and methodology.
- Appendix C provides details on MMUs operating across VHA.
- Appendix D provides comments from the Under Secretary for Health.

[1] Wrey N, Weiss T, Menke T, et al. Evaluation of the VA Mobile Clinics Demonstration Project. *Journal of Health Care Management.* Mar/Apr 1999; 44, 2; ProQuest Research Library, 133-147.

RESULTS AND RECOMMENDATIONS

Finding 1 VHA Lacks Information To Determine Whether Mobile Medical Units Improve Rural Veterans' Health Care

VHA lacks information about the fundamental operations of its MMUs and has not collected sufficient data to determine whether MMUs have improved rural veterans' access to health care. Specifically, VHA does not know the number, locations, purpose, patient workloads, and operating costs of its MMUs. Furthermore, VHA's Office of Emergency Management did not maintain a current accounting of MMUs enabling it to leverage these resources to respond to local, regional, and national emergencies. Despite these data limitations, VHA plans to continue operating its MMUs, as well as fund additional MMUs through FY 2015.

From October 2007 to February 2014, the Office of Rural Health (ORH) reported spending and tracking almost $29 million on MMU projects through its rural health initiative. We determined VHA operated at least 47 MMUs in FY 2013. Of the estimated 47 MMUs, we identified 19 MMUs that were funded by ORH, and 28 MMUs that were funded by either a Veterans Integrated Service Network (VISN) or medical facility. We found MMUs provided various services, such as primary care, mental health, flu vaccinations, and veteran outreach. In addition, we observed a range of vehicles used as MMUs, including converted recreational vehicles (RVs), tractor trailers, trucks, and vans, as well as a bus. We found that some MMUs were used on average as little as 5 days per month to as much as 14 days a month in FY 2013.

However, medical facilities captured MMU-specific workload and operational cost data in VHA's Decision Support System (DSS) for only 6 of the estimated 47 MMUs. Data captured in DSS provide the link between expenses, workload, and patient utilization. Accurately recording MMU-specific data would allow VHA to compare MMU workloads and operating costs with other health care delivery methods, such as Community Based Outpatient Clinics (CBOCs), or to its recent Patient-Centered Community Care initiative.[2]

VHA lacks information about the fundamental operations of its MMUs for the following reasons:

- Absence of specific program responsibility for managing VHA's MMUs

[2] Under Patient-Centered Community Care, medical facilities have the ability to purchase non-VA medical care for veterans through contracted medical providers when medical facilities cannot readily provide the needed care due to geographic inaccessibility or limited capacity. Eligible veterans can access inpatient specialty care, outpatient specialty care, mental health care, and limited emergency care.

- Lack of a clearly defined purpose for MMUs
- Absence of published policies and guidance that provide for effective and efficient MMU operations, including requirements to capture consistent MMU cost and workload data

As a result of the lack of VHA cost and workload data, we were unable to fully address the Committee's concerns about VHA's utilization of MMUs. However, it is apparent that VHA cannot demonstrate whether the almost $29 million ORH spent from October 2007 to February 2014, in addition to unknown medical facility spending on MMU operations, increased rural veterans' access to health care or improved its emergency preparedness. We have concerns that without improved oversight, VHA will not be able to determine the effect of its MMU spending in FY 2015 and beyond.

Basic Information on MMUs Is Lacking

VHA lacks information about the basic operations of its MMUs and has not collected sufficient data to determine to what extent, if any, MMUs have improved rural veterans' access to health care. Specifically, VHA does not know the number, locations, purpose, patient workloads, and operating costs of its MMUs. We obtained ORH's MMU funding data from October 2007 to February 2014. ORH reported spending almost $29 million through its rural health initiative to purchase and operate MMUs, which included costs related to MMU clinical staff salaries, satellite communications equipment and installation, and fuel and maintenance. ORH officials reported currently MMUs can be funded for up to 3 years and funds can be used for the purchase of the MMU and its operations. After ORH funding expires, the MMU is expected to be funded by the operating medical facility.

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* state that controls are an integral part of an organization's planning, implementation, review, and accounting of Government resources in order to achieve effective results. Controls include the plans, methods, and procedures an organization uses to meet its mission, goals, and objectives and, when properly implemented, support its performance-based resource management.

No Clear Purpose for MMUs

VHA has not clearly defined what constitutes an MMU. For purposes of this report, we defined an MMU as a vehicle such as a bus, RV, tractor trailer, truck, or van that can be used to provide services, such as health care and screenings to veterans. We determined VHA operated at least 47 MMUs in FY 2013. Of these estimated 47 MMUs, we identified 19 MMUs that were funded by ORH, and 28 MMUs that were funded by either a VISN or medical facility. Most MMUs had more than one purpose, frequently veteran outreach and primary care. Table 1 provides a summary of MMUs we identified that operated in FY 2013, including the funding source, purpose, and vehicle description.

Table 1. Summary of MMUs Operating in FY 2013

Funding Source	Number of MMUs
VISN or Medical Facility	28
ORH	19
Purpose	
Outreach	29
Primary Care	24
Health Screenings	21
Mental Health	14
Women's Health	6
Prosthetics	5
Other (for example, diagnostics, podiatry, shots)	23
Vehicle Description	
Converted RV	26
Truck	7
Van	6
Bus	5
Tractor Trailer	3

Source: VA OIG VISN Survey, Follow-Up Email Correspondence, and Site Visits

Additionally, we found that VHA's Office of Emergency Management did not maintain a current accounting of MMUs. It is critical that the Office of Emergency Management, which is responsible for coordinating VA medical resources during and after an emergency or disaster, has updated information on VHA's MMUs, their locations, and capabilities. An Office of Emergency Management official told us that during an emergency, resources like MMUs are generally identified through an informal network of contacts across a VISN.

When an emergency or disaster occurs, the Office of Emergency Management needs to know the locations of MMU resources and whether these resources can be mobilized to provide services at local, regional, and national levels to ensure the health and safety of veteran patients and their families, staff, and visitors. The following is an illustration of how an MMU was deployed in VISN 3 to provide veterans access to health care services following Hurricane Sandy.

- Hurricane Sandy, which made landfall in late October 2012, caused widespread flooding that resulted in significant damage to the VA Manhattan Medical Center. An MMU operated by the VA Northport Medical Center was moved onsite to the VA Manhattan Medical Center to provide primary care to veterans. A Northport medical facility official reported the MMU was kept onsite from November 2012 to March 2013.

Utilization of MMUs Varies

We found during our site visits that medical facilities deploy their MMUs in different ways. MMUs were used to provide services, such as primary care, mental health, flu shots, and veteran outreach. Some MMUs were used to transport supplies and clinical staff to expand specialty care at CBOCs. In addition, we observed a range of vehicles used as MMUs, including converted RVs, tractor trailers, trucks, and vans, as well as a bus. Medical facilities reported various utilization rates for their MMUs. We measured the number of operating days for MMUs whose data were captured in DSS. We found that on average, these MMUs operated as little as 5 days to as much as 14 days per month in FY 2013.

While services were provided by the MMUs discussed below, the following examples illustrate the absence of a clearly defined purpose and utilization criteria for MMUs. ORH requires facilities to justify their MMU operations for funding. We found that some facilities, such as the Louis A. Johnson VA Medical Center in Clarksburg, WV, and the VA Maine Healthcare System changed their MMU operations subsequent to ORH funding in response to low veteran turnout or high operational costs.

- In FY 2009, the Louis A. Johnson VA Medical Center began operating an MMU at locations in 19 rural counties. In FY 2012, the medical center changed the MMU's operational schedule in response to changing levels of veteran demand at some locations. Specifically, the MMU stopped servicing Grantsville, WV, because of low veteran demand, while increasing the number of days it serviced Spencer, WV. The MMU's operating hours for Buckhannon, WV; Elkins, WV; New Martinsville, WV; and Sistersville, WV, were also increased. Increasing the MMU's operating hours allowed clinicians to schedule four additional appointments from 8 to 12 per day. The MMU provided services, such as primary care, mental health, and outreach, to veterans in FY 2013. A photograph of this MMU is at Image 1.

Image 1. The Louis A. Johnson VA Medical Center's MMU

Source: VA OIG; Louis A. Johnson VA Medical Center, Clarksburg, WV; 2:53 p.m.; July 24, 2013

- In 2008, the VA Maine Healthcare System in Togus, ME, received funding from ORH to purchase and operate a tractor trailer MMU. Funding from ORH over 4 years totaled approximately $2.9 million. While the tractor trailer MMU has the capacity to be mobile, it was permanently parked in Bingham, ME, in FY 2011 because of factors including high operational costs and unreliable remote connections to VHA's information system. The MMU is open 2 days a week and served about 400 patients in FY 2013. The MMU provides services, such as primary care and eligibility and enrollment.

Image 2. The MMU purchased by the VA Maine Healthcare System in Togus, ME.

Source: VA OIG; Bingham, ME; 10:59 a.m.; July 2, 2013

- VISN 11 used vans as MMUs to expand specialty care, such as prosthetics and orthotics, at 19 CBOCs. Purchased at an average price of about $76,500, vans were used to transport technicians and prosthetic and orthotic supplies, such as braces, diabetic shoes, and inserts. As a result, the VISN reported about 3,000 veterans were able to receive prosthetic and orthotic care at their local CBOC in FY 2013, rather than having to travel to a medical facility. Veterans told us they preferred to receive their prosthetic care at their CBOC because factors, such as gas costs, limited parking, and traffic congestion, made driving to medical facilities in Saginaw, MI, or Marion, IN, difficult. A VISN 11 official reported MMU operations were halted at the Bad Axe, MI, CBOC in FY 2013 because of low veteran demand for prosthetics services. MMU services, however, were increased to 1 or 2 days a week, or about 6 times a month at the Grayling, MI, CBOC in response to greater than expected veteran demand for services.

Image 3. VISN 11 used vans to expand specialty care at 19 CBOCs.

Source: VA OIG; Clare CBOC; Clare, MI; 10:18 a.m.; September 24, 2013

Recording of Workload and Cost Data Inadequate

We determined medical facilities only recorded MMU-specific workload, patient, and operational cost data in DSS for 6 of the estimated 47 MMUs. The purpose of DSS is to serve as a mechanism for integrating VHA's expenses and workload, simulating business issue scenarios, and monitoring patient treatment patterns. Data captured in DSS provide the link between expenses, workload, and patient utilization.

VHA requires the use of DSS to meet the Federal Government's Managerial Cost Accounting requirements. However, we found that at more than half of the sites we visited, the MMU workload and operational costs were included under an accounting code shared by another service line, such as primary care. VHA does not require medical facilities to request VHA's Managerial

Cost Accounting Office to establish an accounting code for each MMU. Use of unique codes would allow DSS to extract cost and workload information specific to each MMU.

DSS has the capacity to generate standard reports on an MMU's total costs, clinic encounters, and average cost per encounter. Accurately recording MMU-specific data would allow VHA to compare MMU workloads, costs, and effect on rural veterans' access to health care with other health care delivery methods, such as CBOCs or rural health clinics. Comprehensive and accurate MMU workload data could be used by medical facility officials to reassess business decisions, such as changing or maintaining an MMU's staffing or route. Furthermore, medical facility officials could use DSS data to determine the costs and benefits of purchasing non-VA medical care from contracted medical providers, such as available through VHA's Patient-Centered Community Care initiative.

Reasons VHA Lacks Information on MMUs

VHA has not designated management responsibility for establishing policy and providing oversight of its fleet of MMUs. A tenet of *Standards for Internal Control in the Federal Government* is that an organization's structure provides the framework for planning, directing, and controlling operations to achieve an organization's objectives. A good internal control environment requires that the agency's organizational structure clearly defines key areas of authority and responsibility and establishes appropriate lines of reporting.

VHA needs to designate management responsibility for developing MMU policy and strategy that leads to well-informed resource allocation and policy decisions based on verifiable data and sound program management principles. Functions a program office would perform include developing a clear definition of what constitutes an MMU, program objectives, organizational responsibilities, and data collection methodologies. If VHA does not define MMU objectives and establish measures to evaluate performance, it cannot determine if MMUs provide a complementary delivery method to improve health care access to rural veterans.

Effects of Knowing Little About MMU Operations

As a result of VHA's limited information, it cannot fully account for its MMUs and ensure that existing resources can be mobilized to respond to emergencies. Furthermore, VHA cannot demonstrate to what extent the almost $29 million ORH spent on MMUs, as well as unknown medical facility spending on MMUs, increased rural veterans' access to health care. We have concerns that without improved oversight, VHA will not be able to determine the effect of its future spending on MMUs in FY 2015 and beyond.

Conclusion

Given that meeting the health care needs of rural veterans is among VA's highest health care priorities, it is vital for VHA to enhance its management of MMUs to measure rural veterans' access to health care. With a defined

purpose and reliable operational and financial data, VHA could assess the effect of MMUs on rural veterans' access to health care, as well as identify MMU implementation challenges, cost effectiveness, and best practices. This would position VHA to fully leverage MMUs to meet the needs of rural veterans and better target any expansions to its MMU fleet to meet identified health care access gaps.

Recommendations

1. We recommended the Under Secretary for Health withhold funding for new mobile medical units until a comprehensive assessment is conducted to assess factors, such as the current composition of the mobile medical unit fleet, services provided, operational days and costs, and the effect on rural veterans' access to health care.
2. We recommended the Under Secretary for Health assign responsibility for developing mobile medical unit policies, objectives, and strategy, and for providing program oversight.
3. We recommended the Under Secretary for Health assign responsibility for maintaining operational data on mobile medical units to ensure mobile medical unit resources can be used as part of VHA's emergency preparedness plan.
4. We recommended the Under Secretary for Health publish necessary policy and guidance to provide for effective and efficient mobile medical unit operations.
5. We recommended the Under Secretary for Health implement a mechanism to ensure that mobile medical unit-specific operations and financial data, such as patient workload, services provided, and costs, are collected in the Veterans Health Administration's Decision Support System.

Management Comments

The Under Secretary for Health concurred with our recommendations. The Under Secretary for Health reported the Deputy Under Secretary for Health for Operations and Management will issue direction for a comprehensive assessment of VHA's use of MMUs and will make recommendations to the Under Secretary for Health based on this assessment. The Deputy Under Secretary for Health for Operations and Management will also issue direction to all VISN Directors to withhold funding for the purchase of new MMUs or for new resources for current MMUs until the Under Secretary for Health has made a decision regarding MMUs in VHA. VHA's actions on recommendations 2, 3, 4, and 5 are contingent on the Under Secretary for Health's decision regarding VHA's continued use of MMUs.

OIG Response

VHA's planned corrective actions are responsive. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. Appendix D provides the full text of the Under Secretary for Health's comments.

Appendix A Background

Rural Veteran Population

VA's Office of the Actuary reported the total veteran population at the end of FY 2013 was around 21.9 million of which about 5.3 million, or 24.2 percent, were considered living in rural areas. Nearly 35 percent of veterans enrolled in VHA live in rural or highly rural areas, according to VA's Office of the Actuary. VHA uses a U.S. Census Bureau definition of urban and rural areas. An urbanized area is any block or block group having a population density of at least 1,000 people per square mile. A rural area is defined as an area with 7 or more, but less than 1,000 people per square mile.

Office of Rural Health Operations

ORH was established in 2007 with a mission to improve access and quality of care for veterans enrolled in VHA living in rural areas. ORH funds MMUs through its rural health initiative. ORH spent almost $29 million on MMU projects from October 2007 to February 2014. Appendix C details MMUs funded by ORH or by a VISN or VA medical facility that operated in FY 2013.

Appendix B Scope and Methodology

Scope

Our audit was conducted from July 2013 through March 2014. The scope of our audit included the estimated 47 MMUs that operated in FY 2013.

Methodology

To determine if there were any criteria applicable to MMUs, we reviewed VHA and ORH policies and procedures, including VA's financial and capitalization policies. We reviewed available studies on MMU operations, outcomes, and costs. To determine VHA's MMU budget and costs, we reviewed ORH-provided budget data, DSS data, and available medical facility MMU cost information. We analyzed ORH strategic plans, interviewed ORH officials and medical facility MMU managers, and reviewed MMU-related project documentation. We also interviewed Office of Emergency Management officials to assess the role of their office in the management and oversight of MMUs.

We visited 14 medical facilities and 1 VISN, where we visited 1 medical facility and 2 CBOCs. We interviewed local officials involved with MMU management and operations, including senior administrators, clinical staff, DSS personnel, and vehicle fleet managers. We walked through MMUs operating at each location. Table 2 details our site visit locations.

Table 2. OIG Site Visit Locations

VISN	Medical Facility	Location
1	VA Maine Healthcare System	Togus, ME
3	Northport VA Medical Center	Northport, NY
4	Louis A. Johnson VA Medical Center	Clarksburg, WV
4	Wilmington VA Medical Center	Wilmington, DE
6	Hunter Holmes McGuire VA Medical Center	Richmond, VA
7	Tuscaloosa VA Medical Center	Tuscaloosa, AL
10	Cincinnati VA Medical Center	Cincinnati, OH
11	VISN 11 Veterans in Partnership	Ann Arbor, MI
16	G.V. (Sonny) Montgomery VA Medical Center	Jackson, MS
17	South Texas Veterans Health Care System	San Antonio, TX
19	Cheyenne VA Medical Center	Cheyenne, WY
19	VA Eastern Colorado Health Care System	Denver, CO
20	Mann-Grandstaff VA Medical Center	Spokane, WA
20	VA Puget Sound Health Care System	Seattle, WA
23	VA Central Iowa Health Care System	Des Moines, IA

Source: VA OIG

VISN Survey

To determine the number of MMUs that were in use during FY 2013 and the services they provided, we conducted an online survey of all 21 VISN Directors. We obtained a 100 percent response rate. We followed up with each VISN via email to obtain information on the type of vehicle that was used as an MMU.

Fraud Assessment

We assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. Alert to fraud indicators, we exercised due diligence in taking the following actions:

- Soliciting the OIG's Office of Investigations for indicators
- Conducting steps to review MMU operations for potential fraud

We did not identify fraud during this audit.

Data Reliability

We determined that we could not use DSS to assess MMU-workload and operational costs because data on only 6 of the estimated 47 MMUs operating in FY 2013 were captured in this system. Furthermore, we determined that DSS data for two additional MMUs operated by the Cheyenne VA Medical Center were not accurate because the costs and workload of both MMUs were captured under one station code. Data on such a small number of MMUs could not be used to draw reliable conclusions about MMUs' workload and costs in FY 2013. Data obtained from our VISN survey were used to validate ORH-reported data on MMU operations. We also confirmed ORH-reported information and selected survey data through interviews of VHA and local medical facility officials during our site visits.

Government Standards

Our assessment of internal controls focused on those controls related to our audit objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix C Services Provided by MMUs Operating in FY 2013

The following table shows the services provided to veterans by MMUs operated by VHA during FY 2013. The table identifies the medical facility and location, the type of services, as well as the type of vehicle.

Table 3. Services Provided by MMUs Operating in FY 2013

Medical Facility and Location	Outreach	Primary Care	Health Screenings	Mental Health	Women's Health	Prosthetics	Other*	Vehicle Type
VA Maine Healthcare System, Togus, ME		X						Tractor Trailer
Bath VA Medical Center, Bath, NY	X						X	Converted RV
Northport VA Medical Center, Northport, NY	X		X				X	Truck
Northport VA Medical Center, Northport, NY	X						X	Truck
VA Hudson Valley Health Care System, Montrose, NY							X	Bus
VA Hudson Valley Health Care System, Montrose, NY				X			X	Converted RV
VA Hudson Valley Health Care System, Montrose, NY	X							Converted RV
James J. Peters VA Medical Center, Bronx, NY	X	X	X				X	Bus
VA New Jersey Health Care System, East Orange, NY	X		X					Converted RV

Medical Facility and Location	Outreach	Primary Care	Health Screenings	Mental Health	Women's Health	Prosthetics	Other*	Vehicle Type
VA NY Harbor Healthcare System, New York, NY	X	X	X				X	Converted RV
VA NY Harbor Healthcare System, New York, NY	X	X	X				X	Converted RV
Louis A. Johnson VA Medical Center, Clarksburg, WV	X	X						Converted RV
Wilmington VA Medical Center, Wilmington, DE	X	X		X				Converted RV
Hunter Holmes McGuire VA Medical Center, Richmond, VA	X	X		X				Converted RV
Hunter Holmes McGuire VA Medical Center, Richmond, VA	X	X		X				Converted RV
Fayetteville VA Medical Center, Fayetteville, NC							X	Converted RV
Fayetteville VA Medical Center, Fayetteville, NC	X						X	Truck
Tuscaloosa VA Medical Center, Tuscaloosa, AL	X	X	X				X	Truck
Orlando VA Medical Center, Orlando, FL		X						Converted RV
James A. Haley Veterans' Hospital, Tampa, FL	X	X	X	X				Converted RV
Cincinnati VA Medical Center, Cincinnati, OH	X							Truck

Medical Facility and Location	Outreach	Primary Care	Health Screenings	Mental Health	Women's Health	Prosthetics	Other*	Vehicle Type
Chillicothe VA Medical Center, Chillicothe, OH	X	X	X	X	X			Truck
Chalmers P. Wylie Ambulatory Care Center, Columbus, OH	X	X		X				Truck
Dayton VA Medical Center, Dayton, OH	X							Converted RV
VA Illiana Health Care System, Danville, IL						X		Van
VA Northern Indiana Health Care System, Fort Wayne, IN						X		Van
Richard L. Roudebush VA Medical Center, Indianapolis, IN						X		Van
Aleda E. Lutz VA Medical Center, Saginaw, MI						X		Van
Edward Hines Jr. VA Hospital, Hines, IL	X	X	X	X	X		X	Converted RV
Kansas City VA Medical Center, Kansas City, MO	X	X	X	X	X			Converted RV
Robert J. Dole VA Medical Center, Wichita, KS	X	X	X	X	X		X	Converted RV
Alexandria VA Health Care System, Alexandria, LA		X	X		X			Converted RV
G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS	X		X					Converted RV

Medical Facility and Location	Outreach	Primary Care	Health Screenings	Mental Health	Women's Health	Prosthetics	Other*	Vehicle Type
Michael E. DeBakey VA Medical Center, Houston, TX							X	Converted RV
Central Arkansas Veterans Healthcare System, Little Rock, AR							X	Converted RV
South Texas Veterans Health Care System, San Antonio, TX							X	Converted RV
VA Texas Valley Coastal Bend Health Care System, Harlingen, TX			X	X			X	Converted RV
West Texas VA Health Care System, Big Spring, TX	XX						X	Bus
Northern Arizona VA Health Care System, Prescott, AZ								Converted RV
Cheyenne VA Medical Center, Cheyenne, WY	X	X	X	X			X	Tractor Trailer
Cheyenne VA Medical Center, Cheyenne, WY		X	X	X			X	Truck
VA Puget Sound Health Care System, Seattle, WA	X	X	X				X	Tractor Trailer
Mann-Grandstaff VA Medical Center, Spokane, WA	X	X	X		X	X	X	Bus
VA Palo Alto Health Care System, Palo Alto, CA	X		X					Van

Medical Facility and Location	Outreach	Primary Care	Health Screenings	Mental Health	Women's Health	Prosthetics	Other*	Vehicle Type
VA Palo Alto Health Care System, Palo Alto, CA	X		X					Converted RV
VA Long Beach Healthcare System, Long Beach, CA	X	X	X	X				Bus
St. Cloud VA Health Care System, St. Cloud, MN							X	Converted RV

Source: VA OIG VISN Survey, Follow-Up Email Correspondence, and Site Visits

**Other services include diagnostics, podiatry, and shots.*

Appendix D Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: April 22, 2014

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Veterans Health Administration Audit of Mobile Medical Units (Project No. 2013-03213-R1-0166) (VAIQ 7463047)

To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1-5.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10AR) at (202) 461-6643.

Robert A. Petzel, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Audits and Evaluations: Veterans Health Administration Audit of Mobile Medical Units

Date of Draft Report: March 26, 2014

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommend the Under Secretary for Health withhold funding for new mobile medical units until a comprehensive assessment is conducted to assess factors, such as the current composition of the mobile medical unit fleet, services provided, operational days and costs, and the effect on rural veterans' access to health care.

VHA Comments

Concur

The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will issue direction for a comprehensive assessment of use of mobile medical units (MMUs) in the Veterans Health Administration (VHA). The DUSHOM will make recommendations to the Under Secretary for Health based on the comprehensive assessment of MMUs.

The DUSHOM will issue direction to all Network Directors to withhold funding for the purchase of new MMUs or for new resources for current MMUs until the Under Secretary for Health has made his decision regarding MMUs in VHA.

VHA actions on recommendations 2, 3, 4, and 5 are contingent on the Under Secretary for Health's decision regarding continued use of Mobile Medical Units in VHA.

To complete this action plan VHA will provide documentation of:

1. Notification to all program offices, Veterans Integrated Service Networks, and facilities prohibiting the use of any funds for the purchase of new MMUs or new resourcing for current MMUs.
2. The Under Secretary for Health's decision regarding use of MMUs in VHA.

In progress July 31, 2014

Recommendation 2. We recommend the Under Secretary for Health assign responsibility for developing mobile medical unit policies, objectives, strategy, and for providing program oversight.

VHA Comments

Concur

VHA must defer any actions on this recommendation until the Under Secretary for Health has decided on the use of MMUs referred to in recommendation 1. Contingent on the Under Secretary for Health's decision, the Under Secretary for Health will assign responsibility for developing mobile medical unit policies, objectives, strategy, and for providing oversight of MMUs in VHA.

To complete this action plan VHA will provide documentation of:

1. The Under Secretary for Health's decision regarding use of MMUs
2. If appropriate, the program office assigned responsibility for developing MMU policies, objectives, strategy, and oversight.

In progress March 2015

Recommendation 3. We recommend the Under Secretary for Health assign responsibility for maintaining operational data on mobile medical units to ensure mobile medical unit resources can be used as part of VHA's emergency preparedness plan.

VHA Comments

Concur

VHA must defer any actions on this recommendation until the Under Secretary for Health has decided on the use of MMUs referred to in recommendation 1. Contingent on the Under Secretary for Health's decision, the Under Secretary for Health will assign responsibility for maintaining operational data on relevant MMUs that can be made available for national emergency response as part of VHA's emergency preparedness plan.

To complete this action plan VHA will provide documentation of:

1. The Under Secretary for Health's decision regarding use of MMUs.
2. If appropriate, the program office assigned responsibility for maintaining operational data on MMUs for national emergency response.

In progress March 2015

Recommendation 4. We recommend the Under Secretary for Health publish necessary policy and guidance to provide for effective and efficient mobile medical unit operations.

VHA Comments

Concur

VHA must defer any actions on this recommendation until the Under Secretary for Health has decided on the use of MMUs referred to in recommendation 1. Additionally the timeframe for developing and publishing policy far exceeds the 1 year requirement for completion of OIG recommendations. However, contingent on the Under Secretary's decision regarding MMUs, the responsible program office identified in recommendation 2 will conduct a review of current VHA guidance and policies and obtain approval on a plan for developing new or revising current VHA guidance or policy on MMUs in VHA. The plan will include a timeline that specifies the timeframes for obtaining stakeholder input on proposed guidance or policy, drafting documents

or materials, obtaining pre-concurrence on draft documents or materials, finalizing draft documents or materials, obtaining final concurrences including any negotiations with Labor Management and adequate time for General Counsel to thoroughly review.

To complete this action plan VHA will provide documentation of:

1. The Under Secretary for Health's decision regarding use of MMUs.
2. If appropriate, the plan for developing new or revising current VHA policy or guidance on MMUs in VHA.
3. Any documents or materials that have been completed within the 1 year timeframe for this OIG recommendation, i.e., by March 31, 2015.

In progress March 2015

Recommendation 5. We recommend the Under Secretary for Health implement a mechanism to ensure that mobile medical unit-specific operations and financial data, such as patient workload, services provided, and costs, are collected in the Veterans Health Administration's Decision Support System.

VHA Comments

Concur

VHA must defer any actions on this recommendation until the Under Secretary for Health has decided on the use of MMUs referred to in recommendation 1. Contingent on the Under Secretary for Health's decision, the Office of Finance will implement a mechanism to ensure that mobile medical unit-specific operations and financial data, such as patient workload, services provided, and costs, are collected in VHA's Decision Support System (DSS).

To ensure all appropriate information is recorded in the Managerial Cost Accounting (MCA) Decision Support System:

- Guidance will be provided to Directors and MCA Site Managers at all applicable medical centers
- MCA Help Desk will monitor facilities to ensure compliance

To complete this action plan VHA will provide documentation of:

1. The Under Secretary for Health's decision regarding use of MMUs.
2. If appropriate, the DSS code for all MMUs in VHA.
3. If appropriate, financial data, patient workload, services, provided, and costs collected through DSS coding as of March 31, 2015.
4. Guidance provided to Directors and MCA Site Managers at all applicable medical centers
5. Report of MC Help Desk monitoring of facility compliance.

In progress March 31, 2015

Veterans Health Administration
April 2014

Appendix E Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nick Dahl, Director Irene J. Barnett Ronald Comtois Lee Giesbrecht Karen Hatch Benjamin Howe Jenna Lamy Jennifer Leonard William Maroon James McCarthy Sunday Okurume David Orfalea Joseph Vivolo

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