Department of Veterans Affairs

Office of Inspector General

AUDIT OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL AND REGIONAL OFFICE CENTER TOGUS, ME

Management has taken action to address concerns about the delivery of medical care and benefits within the state of Maine. Further action is necessary to increase the cost-efficiency and effectiveness of operations.

Report No. 9R1-F05-088
Date: May 3, 1999

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Director (00)

Audit of Department of Veterans Affairs Medical and Regional Office Center Togus, ME

1. In response to a request from the Maine Congressional Delegation, the Office of Inspector General (OIG) conducted an audit of funding, operations, and management issues at the Department of Veterans Affairs Medical and Regional Office Center (VAM&ROC) Togus. Concurrent with the audit, the OIG's Office of Healthcare Inspections (OHI) conducted a Quality Program Assistance review that addressed patient care issues. On February 17, 1999, OHI issued its report and made nine recommendations that addressed several clinical areas requiring improvement.

2. VAM&ROC Togus is a 100-bed general medical, surgical, and psychiatric facility, and is one of 9 New England VA medical facilities comprising the Veterans Integrated Service Network (VISN) 1. Outpatient services are provided to veterans throughout Maine through the VAM&ROC and an expansion of community-based outpatient clinics (CBOC). CBOCs are located in Bangor, Calais, Caribou, and Rumford, ME. The facility also operates a mobile clinic to service veterans in rural Maine. Compensation and pension (C&P) and vocational rehabilitation services are provided to Maine veterans, and their dependents and survivors, by the regional office portion of the VAM&ROC. During Fiscal Year (FY) 1998, the VAM&ROC's budget was about $69 million, and it employed 888 full-time equivalent employees (FTEE). During FY 1998, the medical center treated 2,873 inpatients, 260 nursing home care patients, and performed 159,958 outpatient/staff visits. In comparison to FY 1996, the number of inpatients treated has decreased significantly (26.8 percent); the number of nursing home care patients increased by 2.4 percent; the number of outpatients treated increased by 9.3 percent; the VAM&ROC's funding decreased by less than 1 percent; and, FTEE decreased by 10 percent. As of October 1998, the regional office administered about 23,000 C&P awards valued at $13 million monthly, serviced 700 vocational rehabilitation trainees, and had a backlog of 2,700 unprocessed C&P claims.

3. We found that VAM&ROC management had addressed many of the delegation's concerns regarding the issues of operations and management. Actions were taken both prior and subsequent to management's receipt of the delegation's concerns. For example, during FY 1998, additional CBOCs were opened in the communities of Calais and Rumford, ME; most patients previously referred to Boston area VA facilities for Magnetic Resonance Imaging and radiation therapy are now being treated on a fee for service basis within Maine; to expedite C&P claims processing, the regional office hired

five additional rating specialists; and management also improved communication with various stakeholders, including employees and veterans service organizations.

4. We concluded that the level of funds that the VAM&ROC received was commensurate with the level of funds received by other medical centers within VISN 1. In comparing the periods FY 1996 and FY 1998, we found that changes in workload and FTEE were comparable for Togus and all other medical facilities in VISN 1; however, Togus experienced a decrease of only 0.6 percent in funding, while combined the other medical facilities in VISN 1 experienced a 5.9 percent decrease in funding. This analysis demonstrates that the VAM&ROC has received a proportionally higher share of VISN 1 funds since 1996. In addition, the VAM&ROC's proportionate share of VISN 1 funds further increased in FY 1999, when it received a $2 million, or 3 percent increase in funding, while combined the other facilities in VISN 1 experienced an $8 million, or 1.1 percent decrease in funding.

5. We also found that Togus generally ranked below other VISN 1 facilities in cost efficiency, and that the utilization and productivity of some of its clinics could be enhanced. We identified several areas where VAM&ROC management needs to improve its cost efficiency, enhance the utilization of existing resources, and further improve timeliness of clinical services to veterans. More specifically, we concluded that management needed to take action to: (i) control staffing costs- the indirect to direct staffing ratio ranked the highest in VISN 1 and among the highest in the nation; (ii) more closely monitor clinic utilization- only 5 of 11 clinics had most of their available appointments scheduled; and, (iii) implement pharmacy cost controls- the per patient drug cost for FY 1998 was VISN 1's highest and about 15 percent higher than the VISN's average.

6. While the VAM&ROC's management has taken action to address concerns about the delivery of medical care and benefits services within the State of Maine, further action is necessary to increase the cost-efficiency and effectiveness of operations. We recommend that management reevaluate their strategic plan to incorporate the management action necessary to improve the facility's cost efficiency and effectiveness by: monitoring and controlling staffing costs, improving clinic utilization, and implementing pharmacy cost containment practices.

7. You concurred with the findings and recommendations, and provided an acceptable implementation plan. We will follow-up on the implementation of planned corrective actions.

For the Assistant Inspector General for Auditing,

(Original signed by)
THOMAS L. CARGILL, JR.

TABLE OF CONTENTS

RESULTS AND RECOMMENDATION

Opportunities Exist to Better Utilize Funds

One of Veterans Health Administration (VHA) management's strategic goals is to reduce operating costs through increased efficiencies and cost-effectiveness. VHA management acknowledged that to remain a healthcare provider in the long-term, VHA must demonstrate efficiencies and cost-effectiveness. One of the most important actions in this area was to move from an inpatient to an outpatient based healthcare system. The trend in workload figures demonstrates that the Department of Veterans Affairs Medical Center and Regional Office (VAM&ROC) Togus has made good progress in making the transition to outpatient care. During the audit we identified several areas where VAM&ROC management needs to improve its cost efficiency, enhance the utilization of existing resources, and further improve timeliness of clinical services to veterans. More specifically, we concluded that management needed to take action to control staffing costs, more closely monitor clinic utilization, and implement pharmacy cost controls.

Management Needed to Monitor and Control its Staffing Costs

Our analysis of staffing costs showed that the VAM&ROC's indirect to direct staffing ratios and costs ranked among the highest in Veterans Integrated Service Network (VISN) 1 and the nation. Direct costs are those associated with hands-on patient care. In other words direct costs would include the staff, clinic supplies, and physical clinic space used for an episode of patient care, whether inpatient or outpatient. Indirect costs would include such costs that are not specifically identifiable to an episode of patient care. Generally such costs would be associated with management and administrative functions and other costs associated with maintaining office space. A high ratio of indirect costs to direct costs will contribute to higher overhead costs. We discussed the relationship between indirect costs and overhead costs with management of VHA's Allocation Resource Center (ARC). The ARC developed and maintains the Veteran Equitable Resource Allocation (VERA) funding methodology. *(See Appendix I, page 15 for information on VERA.)* ARC management agreed there is a direct relationship between high indirect costs and high overhead costs and efficiency. The following table demonstrates the increase in the VAM&ROC's indirect to direct staffing and costs. The National Rankings include 145 facilities, and the VISN 1 Ranking includes its 9 facilities. The lower the ranking means the poorer performance level achieved, a ranking of 1 is the lowest possible ranking.

VAM&ROC Togus Indirect Staff and Costs Versus Direct Staff and Costs Compared Nationally and Within VISN 1 FYs 1996-1998				
Fiscal Year	National Rank Staff	VISN 1 Rank Staff	National Rank Costs	VISN 1 Rank Costs
1996	17	3	98	8
1997	8	1	89	8
1998 (3rd Qtr.)	9	1	23	4
Source: Allocation Resource Center Unit Cost Reports for Indirect/Direct Staffing Mix and Resource Utilization				

This comparative analysis demonstrates that Togus' indirect to direct staffing ratio was relatively much higher than those other medical centers competing for the same limited resources and that greater management attention is needed to enhance Togus' cost efficiency. Since the third quarter of FY 1998, Togus has improved its ranking regarding the relationship of its indirect to direct costs. Additionally, further improvements are anticipated by recent actions taken to reduce the number of indirect staff.

Similarly, the VAM&ROC's Nursing Service had one of VISN 1's and the nation's highest ratio of registered nurses (RN) to total nursing staff, and also was rated among the lowest in RN productivity. The ARC measures RN productivity by comparing RN staffing to facility workload/patients treated which is adjusted to consider the age of patients and their severity of illness/level of care. The ratio of RNs to total nursing staff had risen consistently since fiscal year (FY) 1996. This was despite the fact that during the same period the number of acute and long-term care beds requiring specialized RN care had decreased. The VAM&ROC's number of inpatients treated also decreased by 26.8 percent during the 3-year period, but in contrast the RN full-time equivalent employee (FTEE) had only decreased by 0.6 percent.

The following table demonstrates the increase in RNs to other nursing staff and concurrent decrease in RN productivity. The ranking factors are the same as for the above table.

VAM&ROC Togus RN to Other Nurse Staffing and RN Productivity for FYs 1996-1998				
	RN to Other Nursing Staffing		RN Productivity	
FY	National Rank	VISN 1 Rank	National Rank	VISN 1 Rank
1996	47	5	41	3
1997	34	4	37	2
1998	25	3	27	1
Source: Allocation Resource Center Unit Cost Reports for RN Staffing Mix and RN Productivity				

This analysis demonstrates that RN staffing and productivity is clearly an area that VAM&ROC management needs to monitor to determine whether RNs are performing

duties that could more cost-effectively be performed by nursing assistants or licensed practical nurses.

Our analysis of the VAM&ROC's estimated costs for FY 1999 showed that they projected a $5 million shortfall in personnel costs. Management had projected this shortfall since the beginning of FY 1999. However, through the first 5 months of the fiscal year, they hired 24.6 additional FTEE, 9.4 administrative and wage grade, and 15.2 clinical. Management should have implemented more stringent controls to ensure that only emergency hires were made to meet critical operational needs and to prevent the potential to over-obligate funds. Also, prior to hiring any staff, management should analyze the cost efficiency and productivity of current staff, evaluate the impact on current staff of delivering more services on an outpatient basis, and consider the potential to realign staff.

We also noted that temporary employee contracts needed to be properly administered. We reviewed the VAM&ROC's contract with the agency from which the facility hired the largest number of private sector temporaries. We found that 7 private sector temporaries had worked an average of 20 days beyond the end of their contracts. We also found 2 temporaries had worked beyond the 240 workday maximum allowed by VA policy in a 24-month period. These situations occurred because responsible Acquisition and Material Management Service staff had not closely monitored temporary employee contracts.

Management needed to monitor and control its indirect to direct staffing ratios and costs. By more closely monitoring staffing costs, VAM&ROC management can better identify areas where costs are out of line with other VHA facilities and take action to improve its cost efficiency. Further, by improving monitors and controls over hiring of permanent and temporary staff, and evaluating the potential to realign current staff, management can reduce the potential to over-obligate funds.

Monitoring Clinic Profiles Should Improve Clinic Utilization and Productivity

VHA policy states that clinic profiles must be established and maintained for each clinic. The clinic profile is an agreement between the provider and management and should reflect a consensus on how each provider's time should be used. This agreement should balance the needs of the facility with the availability of the provider, and should distribute the provider's time to meet the facility's needs between inpatient care, outpatient care and administrative functions, such as meetings or training, etc. Additionally, clinic profiles must be reviewed annually and updated when the facility's needs and/or the providers' availability have changed.

VHA also requires patient-scheduling systems at all VA medical centers and outpatient clinics. Scheduling of outpatient visits is based on time set aside for clinics in the clinic profiles. Patients should be scheduled at specific time intervals, based on determination of the length of time required for each patient to complete the visit. In other words, new

patients are normally scheduled for 45-60 minutes, while follow-up patients are usually scheduled for 20-30 minutes, with no gaps between appointments. Also, periodic studies of clinic utilization must be made to ensure resources are used effectively, and over-scheduling must be done to compensate for patients who fail to report for a scheduled appointment.

VHA management's customer satisfaction goal is that their service will meet or exceed customer expectations. VHA's timeliness goal is that prompt delivery of services will meet or exceed customer expectations and will be analyzed against the best in the business. Further, the performance goal in this area is to schedule primary care appointments for patients within 7 days of their contacting VA. Similarly, the performance goal is to schedule specialist appointments for patients upon referral within 7 to 10 days of their contacting VA. VHA has stipulated that both of these performance goals should be accomplished by FY 2003. We believe that monitoring clinic utilization through the use of clinic profiles and scheduling will help ensure the VAM&ROC meets both its customer satisfaction and timeliness goals.

Clinics schedules are developed by allocating the time available into specified time slots. Clinic slots can be customized in each clinic to represent the amount of time a patient needs. For example, if a clinic's slot is 15-minutes long, but 45 minutes is needed for a new patient, 3 consecutive 15-minute slots would be scheduled. Therefore, the number of slots does not necessarily represent the number of patients, but all available slots should be scheduled.

To assess clinic utilization, we reviewed a judgmental sample of 11 clinics. We selected four clinics from Dental Service (one for each of the four dentists), three from Medical Service (i.e., one rheumatologist, one cardiologist, and the physician's assistant at the Bangor CBOC) and four from Surgical Service (i.e., one orthopedic surgeon, one general surgeon, the audiology clinic and an eye clinic). We found that clinic utilization had not been well controlled or monitored. Only 4 of 11 clinics reviewed had outpatients scheduled according to the clinic's profile. Only 5 of 11 had most of their available slots scheduled. We also found that while clinic appointment availability was being monitored, periodic studies of clinic utilization were not being accomplished.

Dental Service had not scheduled patient appointments to fully utilize their dental resources, and as a result clinic productivity could be improved. We also found that clinic profiles in cardiology and surgery clinics did not reflect when the providers were actually available for outpatient care, or that the time set aside for outpatient care was used appropriately. In cardiology clinics, we found one cardiologist whose clinic slots were not completely scheduled and one who had outpatients scheduled both during the time allotted for outpatient care and the time allotted for other activities. In surgical clinics, we found surgeons were not using the time set aside for outpatient care to treat outpatients. Management had not reviewed the clinic profiles or closely monitored clinic utilization to ensure that resources were being effectively utilized or to identify opportunities to enhance the timeliness of delivery of services to patients.

Dental Service Clinics

We sampled Dental Service clinic utilization because a January 1998 service organization visit had reported that the Dental Clinic was underutilized. However, in May 1998, VISN 1 authorized the VAM&ROC to hire an additional dentist to implement equal access to care throughout the VISN. The service organization had also reported there was a 14-month backlog for dental prosthetics appointments. The backlog consisted of veterans who had seen a dentist to determine the need for dental prosthetics, but additional appointments with a dentist were needed to measure and fit the prosthetics. To evaluate the Dental Service's clinic utilization and productivity of the dentists, we extracted information from VAM&ROC records to determine actual workload by provider. We selected the first 5 working days of October 1998 as our judgmental sample. We found that Dental Service had not scheduled patient appointments to fully utilize their dental resources. We reviewed the workload for the service's four dentists and found on average that dentists treated four patients per day for an average of 36-minutes each. As a second sample, we reviewed the first 5 working days in October 1997 and again found dentists averaging only four patients per day. The Chief of the service agreed the dentists could see more patients. VAM&ROC management needs to monitor clinic utilization to ensure that scarce medical resources are appropriately utilized and to determine if the timeliness of veterans' access to care can be improved.

Cardiology Clinics

We sampled clinic utilization for cardiology care because, during October 1998, the average waiting times for the next available new and follow-up appointments were 34.5 and 80.1 days respectively. The only standard for specialty care is that referrals must be seen in 7 to 10 days of the date referred. However, the current waiting time for cardiology care exceeded VA standards for primary care of 30 days for new patients and 7 days for follow-up patients. Additionally, a new cardiologist had been hired on August 30, 1998 to reduce the patient backlog. In October 1998, the new cardiologist had two clinics, one for new patients and one for follow-up patients. Of the 27 slots available for new patients, none were scheduled. Although follow-up patients had 47 slots available for scheduling, only 8 slots were scheduled. This scheduling pattern appears inconsistent with the demand for care. Management staff told us that, since the cardiologist was new, his practice was just getting started.

To determine if the new cardiologist's workload had increased, we reviewed both the new and follow-up patient clinics for February 1999. Of the 87 slots available for new patients, 72 were scheduled. Follow-up patients had 27 slots available with 19 scheduled. We concluded that the utilization of the new cardiologist had improved significantly. However, there were still slots available to meet outpatient demand.

To determine if this workload was similar to the other cardiologist, we compared the new cardiologist's workload to the other cardiologist's workload for February 1999. We found

that the other cardiologist had 36 slots available for new patients and had all 36 scheduled. He also had 23 slots available for follow-up patients, but had 58 slots scheduled. Since many of these slots were scheduled outside the time allotted to outpatient clinics, we concluded that the division of time identified in the clinic profile between inpatient, outpatient and administrative responsibilities did not adequately reflect the veterans' needs and the provider's availability.

We concluded that the utilization of the new cardiologist had improved between October 1998 and February 1999, but a significant difference in productivity exists. Management should more closely monitor profiles and workload to ensure that profiles reflect when providers are actually available and needed by patients. Greater management oversight of clinic profiles and workload would better ensure that clinic resources are fully utilized and provide a tool to assess whether the timeliness of clinical services can be improved.

Surgical Clinics

At the time of our review, there was no backlog for appointments to general surgery. Most patients can obtain appointments within 2 or 3 days. We reviewed clinic utilization for October 1998 by sampling one of two general surgeons' clinic profiles. We found that of 142 clinic slots available only 60 or 42 percent were scheduled. Surgical Service management informed us that the general surgeons have inpatient responsibilities and assist each other in operations when they are not otherwise occupied.

To determine if October was representative of outpatient workload, we compared the number of slots available during FY 1998 to the number scheduled and found that on average 49 percent of the sampled surgeon's available outpatient time was used for outpatients. We also reviewed the second general surgeon's clinic schedule for FY 1998 and found that on average that 75 percent of that surgeon's available outpatient time was used for outpatients. Management needed to more closely monitor surgical clinic utilization to determine if this is the best use of these scarce medical resources or if they could be more fully utilized. For example, the primary care clinic had been experiencing some delays in available appointments and there may be an opportunity for the surgeons to temporarily assist in the primary care clinic.

Management Needed to Implement Pharmacy Cost Controls

We found that in September 1997, the VAM&ROC used operating funds to purchase a $500,000 automated prescription refill machine. This purchase was inadequately justified. The VAM&ROC made the purchase without completing a cost-benefit analysis demonstrating how the equipment would improve Pharmacy Service's efficiency and effectiveness. Our analysis showed the equipment generally duplicated work the VHA's Consolidated Mail-Out Pharmacy (CMOP) in Bedford, MA already performed for the VAM&ROC. At the time of this purchase, VISN 1 did not have a policy that required VISN 1's approval of such purchases. Since this purchase, VISN 1 established a policy that all proposed equipment purchases of over $5,000 need VISN 1's approval. After

VISN 1 became aware of the purchase, they had attempted to cancel it. They were unsuccessful due to a high cancellation fee that was built into the purchase order. We were informed the high cancellation fee resulted from the vendor's need to conform to unique specifications.

We also noted that the VAM&ROC's annual drug and supply costs had increased about $4.9 million, or 61 percent during the 3-year period ending with FY 1998. Overall, VISN 1's drug and supply costs increased 44 percent during this time period. During the same period, we also noted that the VAM&ROC's per patient drug cost of $585 in FY 1998 was VISN 1's highest. VISN 1's average per patient drug cost for FY 1998 was $511 or about 15 percent less than the VAM&ROC's. The facility's Pharmacy and Therapeutics Committee acknowledged that the VAM&ROC's failure to adhere to VHA and VISN 1 formularies contributed to these cost increases. While pharmacy costs nationwide have increased, management needs to take steps to implement controls to reduce or contain pharmacy costs.

It is also noteworthy that in March 1998, VISN 1 management had requested the VAM&ROC provide VISN 1 with a report on pharmacy cost containment. The report was to be provided in 60 to 90 days. VISN 1 management informed us that this report had still not been received. In January 1999, the VAM&ROC hired a new Chief of Pharmacy Service who informed us that he plans to address pharmacy cost containment issues, including compliance with formularies.

The Maine Congressional Delegation Requested Audit Coverage of a Range of Concerns that were Grouped into Five Issue Areas

The delegation's concerns grew out of descriptions of problems at VAM&ROC Togus that the delegation had received from veterans, veterans' families and friends, veterans service organizations and some VAM&ROC staff. The delegation forwarded their concerns to VAM&ROC's management on May 21, 1998. On June 12, 1998, management responded. After reviewing management's responses to their concerns, the delegation requested the OIG to conduct an independent audit. The delegation's concerns fell into the following issue areas: veterans' access to care, C&P claims processing, veterans' complaints, management issues, and VA's funding of the VAM&ROC and the VAM&ROC's utilization of their funds.

We found that VAM&ROC's management had addressed several of the operational and management issues raised by the delegation. Some of the issues were addressed prior to and some subsequent to management's receipt of the delegation's questions. Descriptions of some management actions follow.

Veterans' Access to Care

During FY 1998, two additional CBOCs were opened in the rural Maine communities of Calais and Rumford. These were in addition to two CBOCs that had been operating in Bangor and Caribou, ME for several years. Management also increased outreach efforts in rural Maine to make veterans residing in those areas aware of available services. This was done through such measures as press releases and town meetings.

Management had also improved access to care by referring Magnetic Resonance Imaging and radiation therapy patients to fee-basis facilities within the state of Maine. These patients had previously been transported for treatment by van from the VAM&ROC to Boston area VA medical facilities, a round-trip of about 400 miles. VAM&ROC management's decision to utilize fee-basis vendors rather than Boston VA facilities was a quality of life decision, rather than a cost-effective decision. However, VISN 1 management has agreed to pay the additional fee-basis costs for these patients.

Compensation and Pension Claim Processing

Our results indicated the VAM&ROC's Veterans Service Center (VSC) did not have the 5,000-case C&P claim backlog mentioned in the delegation's request. The term backlog refers to all pending C&P claims. Our review of the VAM&ROC's work in progress report (WIPP) for November 20, 1998 showed a total of about 2,725 pending C&P claims. About 560 of these (20 percent) had been pending over 180 days. Two hundred and eighty of the 560 represented appeals of prior VAM&ROC decisions. It is not unusual for appeals to remain pending over 180 days. The remaining 280 were generally original or reopened claims for service-connected (SC) compensation.

To determine whether claims were being properly established and therefore would be reflected in the WIPP report, we analyzed a judgmental sample of 10 randomly selected claims files that had been returned from the claims examiner activity to the file activity. A claim had been properly established in each of the 10 cases. Further, we noted that proper dates of claim had been used in each of the 10 cases. Dates of claim represent the date that claims are initially received by VA, and are eventually used to establish processing timeliness. Timeliness is the elapsed time from the date of claim to the date action on the claim was completed.

We also found that during FY 1998, the VAM&ROC had increased the number of their disability rating specialists from 4 to 9 staff. The additional rating specialists will eventually help improve customer service by reducing the C&P backlog. However, it generally requires several years to train these specialists.

Veterans' Complaints

During our audit, we made ourselves available to discuss any veteran concerns. Concurrently, the OIG's Office of Healthcare Inspections (OHI) conducted a Quality Program Assistance review that addressed patient care issues. During their Quality Assistance Program review, the OHI reviewers had interviewed numerous employees and veterans to solicit their opinions on the VAM&ROC's quality of care and management issues. Three veterans contacted us to complain about the length of time required to process their C&P claims. We reviewed the three claims and discussed them with VSC management. Two of the claims involved Board of Veterans Appeals (BVA) remands of appeal cases. Remands are cases returned by BVA to the office that made the appealed decision, for further work. One case involved a United States Code (USC) 1151 claim. In USC 1151 claims, the claimant is claiming a disability resulted from VA care. The two remand cases had been pending for over 1 year and we noted avoidable delays in both claims.

- In the first case, a veteran had appealed the VAM&ROC's denial of his claim for an increase in his SC condition. Subsequent to receiving a BVA remand, the rating board had requested a general medical examination, when BVA had specified a specialty pulmonary examination was needed. This necessitated scheduling a second examination, causing at least a 60-day delay and unnecessary inconvenience to the veteran. As of March 31,1999, the VAM&ROC had received the necessary examination and had again denied the veteran's claim.

- In the second case, the rating board had twice returned an examination to an examining physician for additional information. In the first instance, additional x-rays were needed. When the rating board received the examination and x-rays, they discovered the examining physician needed to provide additional detailed answers to BVA questions. This detail could have been requested the first time the examination was returned. The failure to do so has resulted in at least a 60-day delay in this case. As of February 12, the veteran had been awarded a partial grant of the increase sought on appeal. However, the veteran had continued his appeal and the case was again being prepared for transfer to the BVA.

- A veteran had filed a USC 1151 claim alleging his disability resulted from care received at the VAM&ROC on March 21, 1998. In this type of claim, the rating board must gather extensive documentation and medical opinions as to what occurred and what disability resulted, before they can reach a decision. As of February 12, 1999, the veteran had been granted a 30 percent SC disability evaluation under USC 1151. In addition, the rating board is continuing to evaluate the veteran's claim for a higher SC evaluation. In our opinion, the delays in processing this claim were not unreasonable.

Management Issues

The delegation was concerned that the VAM&ROC Director had difficulties dealing with employees, veteran service organizations and the union. Our discussions with representatives from these groups indicated they generally felt that from about March 1998 their communications with the Director had improved. The Director has appeared more willing to share information with these groups. Information is shared through such means as town meetings, news releases and bulletins posted throughout the VAM&ROC.

The VAM&ROC Received Funding Commensurate with Funding Provided Other VISN 1 Facilities.

In 1997, VHA changed its traditional facility-based funding to the Veterans Equitable Funding Methodology (VERA). VERA funds VHA's 22 VISNs based on weighted workload. The VERA funding methodology is essentially workload driven in that it allocates funds proportionately to where care is given, on a VISN versus facility basis. VISN 1 allocates their funds based on actual funding received under VERA, prior year operating funds for each facility, adjustments to workload projections, changes in reimbursement levels, and funds retained by each facility through the Medical Care Cost Fund (MCCF). MCCF are funds collected by facilities, in certain instances, to recover the cost of treating nonservice-connected disabilities.

In addition, the final funding allocations are approved by the VISN 1 Executive Leadership Council that includes management from all VISN 1 facilities. Our analysis showed that based on this funding methodology, the VAM&ROC had received funding commensurate with funding provided other VISN 1 facilities. To illustrate, for FYs 1996 – 1998 changes in workload and FTEE were comparable for Togus and all other facilities in VISN 1. However, for FYs 1996–1998, the VAM&ROC experienced a decrease of only 0.6 percent in funding, while combined the other medical facilities in VISN 1 experienced a 5.9 percent decrease in funding. The following table illustrates the comparative performance and budgeting statistics.

Performance and Budgeting Statistics for FYs 1996 - 1998						
	VAM&ROC Togus			**All Other VISN 1 Facilities**		
	FY 1996	FY 1998	3-Year % Chg.	FY 1996	FY 1998	3-Year % Chg.
Workload:						
Inpatients Treated	3,927	2,873	-26.8%	38,249	30,405	-20.5%
NHC Patients Treated	254	260	2.4%	1,346	1,326	-1.5%
Outpatients/Staff Visits	146,344	159,958	9.3%	1,698,252	1,857,221	9.4%
Total FTEE	986	888	-10.0%	9,995	8,967	-10.3%
Budget	$69,185	$68,759	-0.6%	$752,620	$708,077	-5.9%
Source: VISN 1 Chief Financial Officer Allocation Data and the Austin Automation Center workload reports						

In addition, the VAM&ROC's proportionate share of VISN 1 funds further increased in FY 1999, when it received a $2 million, or 3 percent increase in funding while combined the other facilities in VISN 1 experienced an $8 million, or 1.1 percent decrease in funding.

Conclusion

While the VAM&ROC's management has taken action to address concerns about the delivery of medical care and benefits services within the State of Maine, further action is necessary to increase the effectiveness and efficiency of operations. Management action is necessary to improve controls over staffing costs, enhance resource utilization and productivity, and reduce pharmacy costs. Implementation of corrective actions in these areas should improve the facilities cost efficiency, enhance resource utilization, improve services, and better ensure the viability of the VAM&ROC as it continues to compete for limited funds in the future.

Recommendation

We recommend that VAM&ROC management reevaluate their strategic plan to incorporate the management action necessary to improve the facility's cost efficiency and effectiveness. The strategic plan should contain goals, objectives and performance measures that should be monitored to ensure continuous progress is made toward improving the facility's cost efficiency and effectiveness in delivering patient services. Areas requiring greater management attention include monitoring and controlling:

- Indirect to direct staff ratios and cost
- Registered Nurse to other nursing staff ratios and productivity
- Hiring of permanent and temporary staff
- Clinic utilization and productivity
- Pharmacy cost containment efforts

Directors Comments

Concur

Implementation Plan

While there is evidence that increased management attention including monitoring and controlling is necessary in certain areas, we would like to offer the following information to clarify and update management actions taken and planned to improve controls and enhance cost efficiency and effectiveness.

- Indirect to direct staff ratios and cost

  Based on the final FY 1998 Unit Cost Reports (UCR), we acknowledge that our indirect to direct FTEE ratio is the highest within both VISN1 and MCG 4. However, while we recognize that our indirect to direct cost ratio can be improved, we believe it is not significantly out of line with either the VISN, group, or national ratio. Additionally, in the first 6 months of FY1999 we have reduced our indirect FTEE (400 and 500 series), by 28.6 FTEE. This should be reflected in the 2nd qtr FY1999 UCR Reports when they are made available for facility review. We have, and will continue, to use the UCR Reports for comparative review to identify areas for improvements.

- Registered Nurse to other nursing staff ratios and productivity

  As a result of the earlier budget reviews, we have already begun to look at nursing staffing ratio needs. With the consolidation of our two medical wards and impending consolidation of the Psychiatric Observation Unit within the existing Mental Health Ward, we have put together a nursing staffing adjustment plan that calls for the reduction of 27 RNs.

  In the past, we have had considerable difficulty recruiting LPNs and NAs. We have recently stepped up our recruitment efforts, including bonuses for LPNs.

- Hiring of permanent and temporary staff

  Hiring of permanent and temporary staff was done to maintain timeliness and quality of patient care services during a rapid transition to primary care teams. Losses by attrition and shifts to outpatient services had left gaps that were affecting timeliness of services to veterans. As we have gradually adjusted staffing levels during this transition period, it has become possible to reduce temporary and contract staffing almost entirely and place even more stringent controls on hiring of permanent staff.

- Clinic utilization and productivity

  As the organization has moved to redesign some of its care delivery systems, our providers have expanded their clinic responsibilities in an effort to improve access and timeliness. Clinic profiles should have been revised simultaneously and were in many instances.

  We concur that our clinic profiles do not clearly reflect utilization of some of the clinics reviewed by the audit team. Our first course of action will be to review all clinic profiles to ensure that they clearly document what our providers are doing in the delivery of outpatient care.

We also agree that the clinic utilization/clinic productivity issue needs to be more closely monitored. Primary Care has been monitoring this issue weekly for a period of time. Clinical Leadership has agreed to, using the Customer Service Standards as our goal, the following monitors being put in place by June 1999 and reported to management monthly:

- Available Slots
- Slot Utilization
- Time to Next Available Appointment
- No Show Rate
- Unscheduled Visits
- Actions Taken to Improve Access/Productivity

- Pharmacy Cost Containment Efforts

  A new Chief of Pharmacy Service was appointed in January 1999. In this short time, several opportunities for improvement have been identified, including areas where savings are possible. It is not possible at this point to attach a dollar figure to these initiatives.

  Some areas of focus are listed below:

  - Outpatient Pharmacy Analysis (Overall costs/30 vs. 90 day prescriptions)
  - Polypharmacy Costs (Polypharmacy Clinic established)
  - CMOP Costs
  - Conversion to mandatory contract drugs
  - Prescriptions filled and sent outside New England VISN
  - Prescriptions filled that are prescribed by other VISN 1 facilities
  - Trade/Brand Name use, changed to generic
  - Inventory – Replenishment/Dispensing/Provider Education

  Additionally, an extensive review of pharmacy workload and cost is underway. Our area of emphasis is on Outpatient Pharmacy Costs and includes looking at provider prescribing practices. We expect to have a preliminary report by June 1, 1999.

OIG Comments

The comments and implementation plans are acceptable and we consider all issues resolved. We will follow-up on the implementation of planned corrective actions

BACKGROUND

The Department of Veterans Affairs Medical Center and Regional Office (VAM&ROC) Togus, ME, is a 100-bed general medical, surgical, and psychiatric facility, and is one of nine New England healthcare system facilities comprising the Veterans Integrated Service Network (VISN) 1. Outpatient services are provided to veterans throughout Maine through the VAM&ROC and an expansion of community-based outpatient clinics (CBOC). CBOCs are located in Bangor, Calais, Caribou, and Rumford, ME. The facility also operates a mobile clinic to service veterans in rural Maine. Compensation and pension (C&P) and vocational rehabilitation services are provided to Maine veterans, and their dependents and survivors, by the regional office portion of the VAM&ROC.

During Fiscal Year (FY) 1998, the VAM&ROC's budget was about $69 million, and it employed 888 full-time equivalent employees (FTEE). During FY 1998, the medical center treated 2,873 inpatients, 260 nursing home care (NHC) patients, and performed 159,958 outpatient/staff visits. In comparison to FY 1996, the number of inpatients treated has decreased significantly (26.8 percent); the number of nursing home care unit patients treated increased by 2.4 percent; the number of outpatients treated increased by 9.3 percent; and FTEE decreased by 10 percent. In comparing FY 1996 and FY 1998, we also found that changes in workload and FTEE were comparable for Togus and all other medical facilities in VISN 1. However, Togus experienced a decrease of 0.6 percent in funding, while combined the other medical facilities in VISN 1 experienced a 5.9 percent decrease in funding. As of October 1998, the regional office administered about 23,000 C&P awards valued at $13 million monthly, serviced 700 vocational rehabilitation trainees, and had a backlog of 2,700 unprocessed C&P claims.

On May 21, 1998, the Maine Congressional Delegation sent the Director, VAM&ROC Togus, ME, sixty delegation questions and twenty-two questions from veterans and veterans service organizations concerning management and patient care issues at the facility. The VAM&ROC's management responded on June 12, 1998. The Maine Congressional Delegation requested assistance from the Office of Inspector General (OIG) to perform an independent audit of VAM&ROC operations, including management, funding, resource allocation, access to and quality of medical care at the VAM&ROC and its rural satellite clinics. The OIG's Office of Audit would answer the management, funding, resource allocation, and access to care issues. Concurrent with our audit, the OIG's Office of Healthcare Inspections (OHI) conducted a Quality Program Assistance review that addressed the patient care issues. On February 17, 1999, OHI issued their report and made nine recommendations that addressed several clinical areas requiring improvement.

In October 1995, the VA healthcare system began to transform from a confederation of individual medical centers and clinics focused primarily on inpatient care to a fully integrated system of healthcare delivery. The new approach emphasizes primary and ambulatory care. VA has two different funding mechanisms for allocating funding to the networks: by General Purpose (formerly Model) and Specific Purpose (formerly Non-Model) funding. For FY 1998, VA's Medical Care appropriations were divided about $15 billion or 89 percent in General Purpose funds and about $2 billion or 11 percent in Specific Purpose funds. The current General Purpose funds are allocated based on quantifiable workload measures or the Veterans Equitable Resource Allocation (VERA) methodology. Specific Purpose funds have, in many cases, restrictions and must meet one of three criteria: efficiency, national support, or a legal/programmatic requirement. We will discuss how the VERA allocates General Purpose funding to the 22 networks tasked to administer VA services to the nation's 26 million veterans.

On April 1, 1997, VA implemented the VERA, setting two national healthcare prices to correct historic geographic funding imbalances by allocating funds fairly according to the number of veterans having the highest priority for healthcare. In other words, VERA was created to allocate resources more proportionately to where care was given. For FY 1998, VERA allocated about $15 billion of General Purpose funds based on a reimbursement level of $2,604 per veteran for "routine" healthcare needs and a complex care price of $36,960, typically for long-term needs. Continuing the shift to preventive outpatient care, the VERA methodology in FY 1999 included a reimbursement level for one-time outpatient visits such as a health fair participant. The FY 1999 reimbursement levels were Basic Care at $2,857, Basic Single Outpatient Visit at $66, and Complex Care at $36,955. One must consider the complexity of care when analyzing funding allocations, in general tertiary care facilities provide more complex care and tend to receive more funding. VAM&ROC Togus is not a tertiary care facility. For FY 1999, the VAM&ROC's workload breakdown was 96.5 percent in total basic care and 3.5 percent in complex care.

VERA includes a capping strategy to ensure that no VISN will lose more than 5 percent of the prior year's allocation. For the 3 years ended FY 1999, VERA General Purpose funding has remained unchanged at about $15 billion, but VISN 1's funding has decreased the most nationwide, by $60 million or a 7.1 percent shift. The VERA methodology acknowledges geographic differences and its design gives the VISNs with above average cost per patient the opportunity to better utilize their limited funding by improving cost efficiency and effectiveness. For FY 1998, VISN 1 had the highest average cost per patient at $5,471 ($863 higher than the average cost per patient at the other 21 VISNs). The Veterans Health Administration (VHA) had to allocate additional funding of about $5 million to VISN 1 in FY 1999 to provide for newly decentralized programs. The additional funds were necessary due to the impact of the 5 percent capping limitation.

VHA holds the 22 networks accountable for allocating the resources in their geographic areas. VISN 1 has the largest legislative contingencies totaling 6 states and averages about 4.8 percent of VHA total workload. VHA has provided guidance principles for resource allocation from the networks to its facilities. Each network develops its own internal resource allocation methodology. Network funding methodologies are submitted to VHA Headquarters for approval each fiscal year.

VISN 1 allocates their funds based on actual funding received under VERA, prior year operating funds for each facility, adjustments to workload projections, changes in reimbursement levels, and funds retained by each facility through the Medical Care Cost Fund (MCCF). MCCF are funds collected by facilities, in certain instances, to recover the cost of treating nonservice-connected disabilities. The following table shows VISN 1 allocations for the 3-year period ending FY 1999. The table also illustrates that Togus received proportionate increases in available VISN funds over the 3-year period.

VISN 1 Funding Allocation to Its Facilities for FYs 1997-1999 (000's)					
		VAM&ROC Togus		**All Other Facilities**	
FY	Total Facility Funding	Funding	% of VISN 1	Funding	% of VISN 1
1997	$797,241	$68,313	8.6%	$728,928	91.4%
1998	$776,836	$68,759	8.9%	$708,077	91.1%
1999	$771,319	$70,819	9.2%	$700,500	90.8%
3-Year % Change		3.7%		-3.9%	
Source: VISN 1 Chief Financial Officer Allocation Data					

VAM&ROC Togus management through the Medical Center Resource Board allocates the resources to its service lines or fund control points. All service line managers prepare and present their annual budget to the Medical Center Resource Board. The Resource Board determines the final budget for all service line resource allocations. After this annual process, if a service lines needs more funds, then a request must be submitted to the Resource Board for both staffing (i.e., replacements and additions) and resources (i.e., supplies and equipment). When we discussed this year's budget process with many of the service chiefs, the consensus was that each service received the funding they requested.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The purpose of the audit was to respond to a request from the Maine Congressional Delegation that the Office of Inspector General (OIG) perform an independent audit of funding, operations, and management issues at the Department of Veterans Affairs Medical Center and Regional Office (VAM&ROC) Togus Maine. Concurrent with our audit, the OIG's Office of Healthcare Inspections conducted a Quality Program Assistance review that addressed patient care issues.

Scope and Methodology

To assess the delegation's concerns and VAM&ROC's management response, we focused on issues related to resources/funding, clinic utilization, management, VAM&ROC adjudication of claims, and other (i.e., veterans service organization, and Congressional complaints).

We judgmentally sampled each of the following areas:

- Workload Performance for the Regional Office and Dental Service
- Appointment Scheduling and Clinic Utilization
- Temporary Employment Contracting

For each sampled area, we analyzed the selected areas to the supporting documentation (i.e., beneficiary claims file and patient records), reviewed the applicable policy and procedures, and compared to other applicable VA databases. Our scope was limited to accuracy, reported productivity, appropriateness and timeliness of claims processing. In cases where we questioned VAM&ROC's management actions, we requested their comments. All issues were resolved.

In addition to our judgmental samples we also:

- Reviewed the VAM&ROC's responses to the delegation's questions on funding, operations, and management issues and found that they were substantially accurate.
- Reviewed Veterans Equitable Resource Allocation methodology and compared the funding received by Veterans Integrated Service Network (VISN) 1 to the other 21 VISNs for Fiscal Years (FYs) 1997 through 1999.

- Reviewed VISN 1 funding process and allocations to its nine facilities for FYs 1997 through 1999.

- Compared Resource Utilization, Cost Efficiency, Productivity, and Staffing Mix for all VISN 1 facilities, and also Togus' Medical Center Group.

- Reviewed the VAM&ROC's resource allocations for FYs 1997 through 1999 (i.e., Status of Funds Reports, minutes of the Medical Center Resource Board, Executive Management Committee, and Pharmacy and Therapeutics Committee).

- Reviewed the Organizational charts for all service lines.

- Conducted interviews with VAM&ROC and VISN 1 management, VAM&ROC Service Chiefs, staff and veterans regarding resource allocations, management communication, staffing, and other concerns.

- Reviewed service lines' space utilization.

- Toured the facility.

- Discussed the review process and findings at various stages of the review with VAM&ROC and VISN 1 management.

The audit was conducted in accordance with generally accepted government auditing standards and included such tests of procedures and records, as we considered necessary under the circumstances.

FINAL REPORT DISTRIBUTION

VA Distribution

The Secretary of Veterans Affairs
Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Financial Management (004)
Assistant Secretary for Planning and Analysis (008)
Assistant Secretary for Congressional Affairs (009)
General Counsel (02)
Deputy Assistant Secretary for Congressional Liaison (60)
Deputy Assistant Secretary for Public Affairs (80)
Director, Management & Financial Reports Service (047GB2)
Chief Network Officer (10N)
Chief Financial Officer (17)
Director, Veterans Integrated Service Network 1
Director, VAM&ROC Togus, ME (402/00)

Non-VA Distribution

The Maine Congressional Delegation:
- The Honorable Olympia J. Snowe
- The Honorable Susan M. Collins
- The Honorable Thomas H. Allen
- The Honorable John E. Baldacci

Office of Management and Budget
U.S. General Accounting Office
Congressional Committees:
- Chairman, Senate Committee on Veterans' Affairs
- Ranking Member, Senate Committee on Veterans' Affairs
- Chairman, House Committee on Veterans' Affairs
- Ranking Democratic Member, House Committee on Veterans' Affairs
- Chairman, Senate Committee on Appropriations
- Ranking Member, Senate Committee on Appropriations
- Chairman, House Committee on Appropriations
- Ranking Democratic Member, House Committee on Appropriations
- Chairman, Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations
- Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations
- Chairman, Senate Committee on Governmental Affairs
- Ranking Member, Senate Committee on Governmental Affairs