



Department of
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Office of Inspector General

Combined Assessment Program Review of the VA Central California Health Care System Fresno, California

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VA Office of Inspector General Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's effort to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

**Combined Assessment Program Review of the
VA Central California Health Care System
Fresno, California**

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Central California Health Care System (CCHCS). The purpose of the review was to evaluate selected CCHCS operations, focusing on patient care quality management (QM) and financial and administrative management controls. During the review we also provided Fraud and Integrity Awareness training to 120 CCHCS employees.

The CCHCS is a 145-bed tertiary care facility, providing medical, surgical, and psychiatric care. The CCHCS's Fiscal Year (FY) 2000 budget is \$65.8 million and the staffing level is about 797 employees. In FY 1999, the CCHCS provided care to 18,662 unique patients.

Patient Care Quality Management. CCHCS management had created an environment that supported quality patient care and performance improvement. The CCHCS had a comprehensive QM program that provided strong oversight of the quality of care. To improve patient care management, the CCHCS needed to: (a) perform required inspections of contract nursing homes; (b) complete medical records more promptly, reduce the backlog of unfiled medical record documents, and ensure that medical records are securely stored; and (c) address various patient care environment, staffing, and appointment scheduling issues.

Financial and Administrative Management Controls. The CCHCS's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls, the CCHCS needed to: (a) reduce medical and engineering supply inventories; (b) strengthen information technology security by promptly deactivating unneeded user access to information systems and by designating an alternative computer processing site; (c) include expired drugs in controlled substances inspections; (d) reconcile accounts receivable and pursue delinquent debts; and (e) ensure that signed means test forms are obtained from patients.

CCHCS Director Comments. The CCHCS Director agreed with the CAP review findings and provided acceptable plans to take corrective action. (See Appendix II for the full text of the Director's comments.) We consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

(Original signed by:)

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Introduction

VA Central California Health Care System

The VA Central California Health Care System is an affiliated system providing tertiary medical, surgical, and psychiatric care, extended care, and residential alcohol and drug care. Outpatient care is provided at the Fresno campus and at community based outpatient clinics located in Atwater and Tulare, California. The CCHCS is one of seven facilities in Veterans Integrated Service Network (VISN) 21. The CCHCS's primary service area includes Fresno and five contiguous counties in central California. The veteran population in the service area is 130,000.

Programs. The CCHCS has 65 acute care beds, 60 geriatric extended care beds, and 20 residential alcohol/drug beds, and operates several specialty programs such as cardiology and ophthalmology. In FY 1999, the CCHCS's medical research program had four active projects and a budget of \$39,000. The CCHCS also provides inpatient and outpatient diagnostic services to the Lenmore Naval Air Station and to several active duty and reserve military units.

Affiliation. The CCHCS is affiliated with the University of California San Francisco School of Medicine and with several other medical schools and supports 48 medical resident positions in five training programs. Clinical training rotations are also provided for 20 medical students and 100 nursing students.

Resources. In FY 1999, CCHCS medical care expenditures totaled about \$65.1 million. The FY 2000 budget is \$65.8 million, 1.1 percent more than the FY 1999 budget. The CCHCS's FY 1999 staffing totaled 797.4 full-time equivalent employees (FTEE) and included 42.0 physician FTEE and 165.0 nursing FTEE.

Workload. In FY 1999, the CCHCS treated 18,662 unique patients, a 5.6 percent increase from FY 1998. Inpatient care was provided to 3,067 patients, and the average daily census was 111.8, including extended care and residential alcohol/drug patients. Outpatient care was provided to 18,326 patients who made a total of 175,066 visits.

Objectives and Scope of CAP Review

The purposes of the CAP review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to CCHCS employees.

Patient Care Quality Management Review. Office of Healthcare Inspections staff reviewed selected clinical activities to evaluate the effectiveness of Quality Management and patient care management. The QM program is a set of integrated processes designed to monitor and improve the quality of patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and measures to ensure staff competence. To meet the review objectives, we inspected patient care areas,

reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. As part of the review, we used questionnaires and interviews to survey employee and patient opinions about quality of care, timeliness of service, and satisfaction with care received. The review covered the following 14 clinical operations and monitoring functions:

Acute Medical-Surgical Unit	Radiology
Primary Care Clinics	Nutrition and Food Service
Specialty Care Clinics	Medical Information
Geriatrics and Extended Care Unit	Utilization Management
Mental Health Care	Infection Control
Pathology and Laboratory	Risk Management/Patient Safety
Pharmacy	External Oversight

Financial and Administrative Management Review. Office of Audit staff reviewed selected financial and administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, to prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed managers and employees, and reviewed pertinent administrative, financial, and clinical records. The review covered the following 19 activities and management controls:

Supply Inventory Management	Part-Time Physician Timekeeping
Construction Planning	Lease Agreements
Purchase Card Program	Service Contracts
Fee Basis Care Program	Nursing Home Care Contracts
Agent Cashier Operations	Pharmacy Security
Equipment Accountability	Equipment Acquisition
Information Technology Security	Information Technology Acquisition
Controlled Substances Inspections	Unliquidated Obligations
Accounts Receivable	Printing and Reproduction
Medical Care Cost Fund	

Fraud and Integrity Awareness Training. Office of Investigations special agents conducted four Fraud and Integrity Awareness briefings for CCHCS employees. About 120 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review covered CCHCS operations for FY 1999 and FY 2000 through March 2000. The review was done in accordance with the Inspector General's Standard Operating Procedures for Combined Assessment Program Reviews.

Results and Recommendations

Patient Care Quality Management

The QM Program Was Comprehensive and Patient Care Management Was Generally Effective

CCHCS management had created an environment that supported quality patient care and performance improvement. The CCHCS had a comprehensive QM program that provided effective oversight of the quality of care using national and local performance measures, risk management, utilization management, occurrence screening, and peer review. Each service made a periodic presentation on its important quality of care issues to the Clinical Executive Council.

In June 1998, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performed its most recent triennial accreditation survey of the CCHCS. JCAHO made only two recommendations, one on the use of restraints in the evaluation unit and the other on the lack of a physician order for a minor non-invasive diagnostic monitor. The CCHCS responded with action plans, and JCAHO subsequently removed the two recommendations.

Ongoing quality of care monitors included patient safety/risk management, infection control, restraint use, medication use, operative procedures, blood products use, and medical record documentation. We reviewed two administrative boards of investigations and one root cause analysis CCHCS employees conducted over the past 12 months. We found these review processes to be sound and the conclusions and corrective actions to be relevant. For example, a patient smuggled a disposable razor onto the special care unit and used it to cut his wrists. CCHCS employees investigated the incident and recommended that care providers be sensitized to signs of suicidal feelings and that procedures for checking patient clothing and other personal possessions be strengthened. CCHCS managers followed through on both recommendations, and similar incidents have not occurred since.

The Bedside Glucose Testing Program Was Commendable. The CCHCS had a comprehensive and well-managed bedside glucose testing program (a form of ancillary testing) for diabetic patients who needed frequent glucose checks. The program coordinator had established excellent procedures for monitoring glucose testing, controlling the quality of testing, following up on critical test results, and providing training to ensure staff competence. Every day, the nursing staff downloaded all bedside glucose test results into the CCHCS laboratory computer program, which ensured immediate access to test results. This approach was an improvement over the practice at many other VA facilities where nursing employees either download bedside test results less frequently than every day or manually enter results into the laboratory computer program. We complimented the ancillary testing coordinator and the nursing staff for the highly effective bedside glucose testing program. In addition to bedside glucose testing, CCHCS clinicians had implemented the use of hand held blood gas analyzers for bedside testing of blood oxygen and carbon dioxide levels. This practice had reduced the turn around time for test results from 20 minutes to 5 minutes.

Dietitian Management of Patients at Nutritional Risk Was Comprehensive. We reviewed medical records for two focused clinical activities -- management of very low blood glucose levels (5 records) and management of low serum albumin levels in long-term care patients (33 records). These two topics were selected for study on all FY 2000 CAP reviews and the results may be summarized in a multi-facility report. A low level of albumin in the blood indicates that the patient is nutritionally compromised. We reviewed clinician assessment and management of patients once the low albumin value was obtained and concluded that the dietitian had performed thorough assessments that were well-documented, including weight analysis (88 percent of the analyses reviewed), nutritional status (85 percent), and nutrient needs (82 percent).

Recommendations for Improving Patient Care Management

Contract Nursing Home Care -- Annual Inspections Should Be Performed

The CCHCS had not been performing the required annual inspections of community nursing homes that provided care to veteran-patients under contracts with the CCHCS. As of March 2000, the CCHCS had contracts with seven community nursing homes, with 11 veteran-patients placed in three of the homes. Veterans Health Administration (VHA) policy requires that contract nursing homes be inspected each year to ensure that good care is provided. These inspections should be performed by an interdisciplinary team of facility employees, with the objective of evaluating care practices and monitoring systems. Because of an apparent misunderstanding, CCHCS managers had discontinued these inspections in 1997. The Chief of Social Work Service was aware of this problem and had developed a plan to reinstitute the inspections and to complete them all by April 1, 2000.

We concluded that the inspection plan was sound but that the CCHCS Director needed to ensure that there was follow-through on the plan so that (a) contract nursing homes are inspected every year and (b) inspection procedures are thorough and include follow-up on the correction of identified deficiencies. The Director agreed and reported that an interdisciplinary inspection team had been formed and that as of June 2000 the team had inspected all contract nursing homes and that deficiencies found had been corrected. The CCHCS had also revised its policies to require annual inspections of all contract nursing homes. The corrective actions are acceptable and we consider the issue to be resolved.

Medical Information -- Medical Records Should Be Promptly Completed and Securely Stored

We noted three medical information issues that could adversely affect patient care. First, the CCHCS needed to improve the timeliness of completing medical records. The completed medical record on a discharged patient should contain all required documentation, including the discharge summary and necessary clinician signatures. The JCAHO standard requires that at least 50 percent of all inpatient records should be completed within 30 days of the patient discharge. The CCHCS had been struggling to maintain a completed record level of 50 percent. As of February 2000 the level was 45 percent. The Chief of Medical Information recently implemented a new process for tracking incomplete records for all care providers and notifying

them about their incomplete records. She was optimistic that the new process would improve record completion.

Second, the CCHCS had more than 45 linear feet (about 210,000 pages) of unfiled medical record documents. The Chief of Medical Information estimated that half of the documents were handwritten progress notes and consults. Because of the absence of these records, clinicians making patient care decisions could miss vital information. While the Chief of Medical Information assured us that her staff was very responsive when clinicians asked them to search for requested documents in the unfiled material, it was an inefficient process.

Third, during our review we observed unsecured medical records in the clinic areas. Unsecured records pose a risk because patients may be able to view other patients' records, resulting in a breach of privacy, and/or may be able to view their own records and possibly misinterpret information or even remove important documents. While medical records must be readily available to clinicians, they must also be properly secured at all times.

We concluded that the CCHCS Director needed to ensure that a plan is developed to: (a) complete medical records more promptly; (b) reduce the backlog of unfiled medical record documents; and (c) ensure that medical records are securely stored. The Director agreed and reported that a revised medical records tracking process had been implemented and the completed record rate had increased from 45 to 67 percent. Staff overtime had been approved and 2.0 FTEE temporary staff had been hired to eliminate the backlog of unfiled medical record documents by September 2000. Medical records would be picked up from exam areas and baskets more frequently and for added record security wall pockets for the records would be mounted in exam rooms by July 2000. These corrective actions are acceptable and we consider the issue to be resolved.

Patient Care Environment, Staffing, and Appointment Scheduling -- Various Issues and Concerns Should Be Addressed

During the review we noted several issues and concerns that did not require individual recommendations but that collectively warranted management attention. Management agreed to evaluate these issues and to take corrective action as necessary:

Patient Care Environment. The CCHCS main hospital building and other patient care areas were clean and we did not note any significant sanitation deficiencies. However, several employees and patients expressed concerns about cleanliness and suggested that the CCHCS was not always as clean as it was during our review. CCHCS managers acknowledged that keeping all areas clean was sometimes a problem, largely because of the age of the building. Management had been giving ongoing attention to this problem.

We noted that carts, patient lifts, and gurneys were parked in the hallways throughout the CCHCS, presenting a potential safety hazard. This problem had been partially caused by ongoing inpatient ward renovation projects, which had temporarily reduced storage space. Managers agreed that alternative storage space needed to be found and that hallways should be kept clear except for carts that are in active use and that can be easily moved in an emergency.

Pharmacy Service Staffing Shortages. Pharmacy Service had a critical staffing shortage, with 6 of 15 pharmacist positions vacant. All pharmacists had been assigned to provide basic medication dispensing coverage. Because of this, they did not provide clinical services in the ambulatory care clinics and provided only minimal support in the inpatient setting. The pharmacists whom we interviewed expressed frustration with the volume and with the lack of clinical interaction. For example, the pharmacist assigned to the nursing home found it difficult to complete mandated nursing home reviews when she was also assigned to dispense medication. The resulting lack of professional satisfaction could lead to more pharmacists seeking other employment and could also discourage new applicants from joining the pharmacy staff. In addition, the absence of a clinical pharmacy program and the lack of practitioners to mentor students could lead to the loss of the affiliation with the University of Pacific School of Pharmacy and therefore the loss of a possible source of new employees.

The Acting Chief of Pharmacy Service acknowledged the staffing shortage issue and described his plan for aggressively recruiting to fill vacant positions. One concern in attracting viable candidates was the salary structure. As a first step to provide support for the need to offer higher salaries, CCHCS managers planned to conduct a survey which would obtain salary information for community, drugstore chain, and hospital pharmacies.

Staffing Issues Raised by Employees. Several managers and employees indicated a need for more employees and a need to achieve more with existing staff. Only 40 percent of employees who responded to our survey agreed that there was sufficient staff to provide care to all patients who needed it. Many nursing employees in direct patient care positions felt overwhelmed by their workloads. More significantly, they believed that their ability to attend to patient needs was, at times, inadequate. CCHCS managers acknowledged that critical care nurse and licensed vocational nurse recruiting represented significant staffing challenges.

The results of our inpatient survey indicated that basic needs were being met despite the nurse staffing challenges -- 94 percent of inpatients felt that call lights were answered within 5 minutes, and 100 percent of inpatients who experienced significant pain felt that they received adequate medication or treatment to relieve the pain.

Waiting Times for Scheduling Clinic Appointments. The CCHCS needed to reduce the time that patients had to wait to obtain appointments for some clinics. CCHCS managers acknowledged that patients needing appointments for certain clinics had to wait more than 45 days. For example, waiting times to obtain appointments were 55 days for primary care/medicine, 52 days for urology, and 85 days for neurosurgery. The CCHCS had targeted waiting times for appointments in the primary care clinics as an improvement area. CCHCS managers indicated that once the primary care project was completed they would focus their efforts on reducing waiting times for appointments in the specialty clinics.

Patient and Employee Survey Results. As part of the CAP review we obtained perceptions from employees and patients through the use of questionnaires and interviews. In the employee questionnaire, we covered topics such as job satisfaction, staffing, and quality of care. In the patient questionnaires, we covered topics such as timeliness, access, and courtesy. A total of 178 employees and 130 patients completed questionnaires. The overall results of the surveys were very positive. The specific results listed below may be of interest to management in their

ongoing efforts to improve customer service and employee morale. (We sent the full survey data to CCHCS management.)

- VHA policy requires one physician to be in charge of each inpatient's care. Only 70 percent of the inpatients surveyed responded that one physician was in charge of their care.
- Employees expressed dissatisfaction with the recognition and awards process. Only 50 percent of surveyed employees perceived that recognition and awards reflected performance.
- Fifty percent of the employees rated the CCHCS's quality of care as excellent or very good, and 76 percent would recommend the CCHCS to an eligible friend or family member.
- Sixty-four percent of the patients surveyed rated the quality of care as excellent or very good, and 94 percent would recommend the CCHCS to an eligible friend or family member.

We concluded that the CCHCS Director needed to ensure that the issues and concerns discussed above are reviewed and that corrective action is taken as warranted and feasible. The Director agreed and reported that the corrective action on several issues had begun or had been completed. For example, to address the Pharmacy Service staffing shortage the CCHCS had hired 3.0 pharmacist FTEE and 3.0 pharmacy aide FTEE and had performed a salary survey to obtain support for the need to offer pharmacy staff higher salaries. The corrective actions are acceptable and we consider the issue to be resolved.

Financial and Administrative Management

Management Controls Were Generally Effective

CCHCS management had established a positive internal control environment, the financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. As illustrated by the following examples, we found no significant deficiencies in several of the activities reviewed.

Prosthetic Supply Inventory Management Was Effective. The Prosthetics and Sensory Aids Service's practice of ordering supply items on an as needed basis and having vendors deliver the supplies directly to patients' homes was a best practice that could be shared with other VHA facilities. Using this practice, the service had reduced their inventory to 22 items (value = \$7,536). Our review of the 22 items found that none had inventory on hand that exceeded current needs.

Construction Projects Were Properly Planned. As of March 2000, the CCHCS had begun or planned to begin 10 construction projects. We reviewed the justifications for these projects and inspected the areas affected by the planned construction. We concluded that all 10 projects were well planned, had been properly justified, and were needed to correct significant functional deficiencies. The CCHCS had two minor construction projects in the design phase (cost = \$4.2 million) to construct private bathrooms in the hospital's 5E wing and to replace aging chillers with higher capacity equipment. The remaining eight projects were nonrecurring maintenance projects (cost = \$1.4 million) to renovate part of the hospital roof, refurbish the main generator, and correct various safety and handicapped access deficiencies.

Purchase Card Transactions Were Promptly Reconciled and Approved. The CCHCS had 38 employees who were authorized to use purchase cards. These employees held a total of 59 cards. Purchase card transactions were reviewed by 16 approving officials. During the 6-month period September 1999 through February 2000, the CCHCS had 2,379 purchase card transactions totaling \$978,477. Transaction reconciliations and approvals were performed promptly, with 91 percent of transactions reconciled by cardholders within 5 days as required and 100 percent of transactions approved by approving officials within 14 days as required. To assess the quality of purchase card training, we reviewed training material and interviewed the Acting Purchase Card Coordinator and several cardholders. The training material was informative and complete. In addition to the initial training for all new cardholders, there were opportunities for additional or corrective training. Cardholders expressed satisfaction with the training and with the administration of the purchase card program.

Fee Basis Care Was Properly Administered and Costs Were Controlled. The fee basis care program was operating effectively. We reviewed records pertaining to a judgment sample of veterans who received fee basis care and found that the veterans were eligible for the care and that the care had been properly authorized. The CCHCS was using VA's Prospective Payment System software to pay fee-basis inpatient care bills and the Standard Medicare Participating

Physicians Fee Schedule to pay fee-basis outpatient bills. These controls ensured that payments were at or below benchmark Medicare rates.

Agent Cashier Operations Were Sound. Our review of Agent Cashier operations found no deficiencies. We requested and observed an unannounced audit of the Agent Cashier. CCHCS staff conducted the audit properly. The audit found no overages or shortages in the Agent Cashier's funds. We analyzed recent cash disbursements and concluded that the amount of the cash advance was appropriate. The combinations to the Agent Cashier's and the alternate Cashiers' safes had been properly secured. Agent Cashier unannounced audits were generally performed every 90 days as required.

Equipment Was Properly Accounted For and Annual Inventories Were Performed. As of March 2000, the CCHCS had 62 Equipment Inventory Lists (EILs) listing 854 equipment items with a total value of \$19.4 million. To determine if equipment inventories had been performed on a 1-year schedule, we reviewed the inventory records for all 62 EILs. The records showed that all required inventories had been performed within the last year. To test the accuracy of the inventories, we reviewed a judgement sample of 20 equipment items from 7 EILs and were able to account for all 20 items.

Opportunities for Improving Management Controls

Supply Inventory Management -- Excess Medical and Engineering Supply Inventories Should Be Reduced

We evaluated the management of pharmaceutical, engineering, and medical supply inventories to determine if controls were adequate to prevent the build-up of excess inventory. We concluded that Pharmacy inventory management practices were sound but that improvements were needed in the management of engineering and medical supply inventories.

In FY 1999, the CCHCS spent \$5.7 million on pharmaceutical, engineering, and medical supplies. VHA facilities should maintain inventory levels that meet current operating needs. Inventories above those levels should be avoided so that funds are not tied up in excess inventory. Generally, current needs can be met by maintaining inventories at no more than a 30-day supply. For pharmaceutical supplies, current needs can be met by maintaining a 10-day supply because the prime vendor can usually deliver pharmaceuticals within 1 day of ordering. We reviewed inventory management practices in Pharmacy Service and in Facilities Management Service's (FMS), Engineering, Supply Processing and Distribution (SPD), and Warehouse Sections.

Pharmaceutical Supplies. Pharmacy supply managers inventoried and ordered supplies daily, established normal stock levels that reflected 5 to 7 days of stock, and adjusted normal stock levels when usage rates changed. Our review of a judgmental sample of 10 pharmaceutical items found that the inventory for all 10 items was below the 10-day standard.

Engineering Supplies. The Engineering Section did not use an automated inventory system and did not have any inventory records to manage inventories. The absence of an inventory system

prevented the section from using basic inventory controls such as establishing normal stock levels, analyzing usage patterns to determine optimum order quantities, and conducting periodic physical inventories. Instead, supply managers had to rely on their experience and on informal estimates of usage to determine when and how much to order. The absence of written inventory records and normal stock level standards caused supply managers to purchase supplies that exceeded current needs. We reviewed the quantities on hand and the usage rates for a judgment sample of 10 engineering supply items. For 8 of the 10 items, stock on hand exceeded a 30-day supply. Three of the eight items had inventory levels exceeding a 180-day supply.

Medical Supplies. The SPD Section did not use an automated inventory control system to manage medical supply inventories. According to the Chief of SPD, the section had previously used VA's automated inventory management system, the Generic Inventory Package (GIP), but no longer had the expertise to use the system. Instead supply managers referred to records of previous purchases when reordering. Normal stock levels had been established several years ago, but had not been updated and did not reflect current safety level and usage needs. As a result, there had been a build-up of excess inventory in SPD. To test the reasonableness of SPD inventory levels we reviewed a sample of 10 randomly selected supply items and found that levels for all 10 items exceeded a 30-day supply, with the levels ranging from 31 to 365 days of stock and the average being 155 days.

In addition to the medical supplies stocked in SPD, the Warehouse Section maintained an inventory of medical supplies with an estimated value of \$25,000. Most of the medical supplies stocked in the warehouse were the same items stocked in SPD. The warehouse used GIP to control inventory and reorder supplies. However, the normal stock levels set in GIP were higher than necessary to meet current needs. To test the reasonableness of warehouse inventory levels we reviewed a sample of 10 high dollar items stocked by both the warehouse and SPD. For those items warehouse supply stocks averaged 143 days and SPD stocks averaged 90 days. We concluded that the SPD inventory was more than enough to meet current needs without additional warehouse stock. The Chief of FMS agreed that items stocked in SPD should not be also stocked in the warehouse and that warehouse normal stock levels were set too high.

Implementation of GIP. The Chief of FMS also agreed that the overall inventory management of engineering and medical supplies needed improvement. He stated that the implementation of GIP to help manage supplies was a high priority for both FMS and CCHCS management.

We concluded that the CCHCS Director needed to ensure that (a) automated inventory controls are effectively used to reduce engineering and medical supply inventories to levels consistent with current needs and (b) warehouse inventories do not include supplies stocked by SPD. The Director agreed and reported that the CCHCS had begun action to reduce supply inventory levels. The CCHCS had begun implementing GIP and had scheduled GIP training for supply staff. The target date for completing all of these actions is August 15, 2000. The planned corrective actions are acceptable and we consider the issue to be resolved.

Information Technology Security -- Minor Improvements Are Needed to Fully Comply with VA Policy

VA Handbook 6210 specifies procedures for protecting Automated Information System (AIS) resources from unauthorized access, disclosure, modification, destruction, or misuse. Using this handbook and other guidelines, we performed a limited review of AIS security controls. Physical security for the computer rooms and equipment was adequate, back-up tapes were stored off-site, and onsite generators supported local area network computers. Controls were in place to force users to change their passwords every 90 days and to lock out users after three failed password attempts.

Our review identified two areas where security could be enhanced and brought into full compliance with VA policy. First, access to the CCHCS Veterans Health Information Systems and Technology Architecture (VISTA) needed to be promptly deactivated for former users who did not have a current need for access. Second, the CCHCS information system contingency plan should include a detailed prioritization of mission critical systems and designate an alternative processing facility.

VISTA Access. VISTA is the information system that supports critical clinical, financial, and administrative activities. CCHCS Memorandum 162-98-007 established procedures for controlling VISTA access by promptly deactivating access when a user no longer needs it. Information Resource Management (IRM) Service is required to deactivate VISTA access for all employees who separate from the CCHCS and routinely provide service chiefs a list of former users that have not accessed VISTA during the past 90 days. Service chiefs are required to review the list and to notify IRM if any individual's access should be deactivated. The procedures also require Human Resources Management Service to provide IRM with a monthly Personnel Strength Report, which IRM should use to ensure deactivation of VISTA access for separated employees.

To evaluate the effectiveness of VISTA access controls, we compared two February 2000 reports, one listing users with VISTA access and the other showing all employees in the CCHCS's Personnel and Accounting Integrated Data (PAID) system. This comparison identified 571 individuals who had VISTA access but who were not in the PAID system. Of the 571 individuals, 376 were associated with the CCHCS as former employees or as individuals who had worked or were working at CCHCS but were not in the PAID system (such as medical students, residents, and consulting and attending physicians). The remaining 195 individuals were employees at other VA facilities such as the VISN Headquarters and the VA Regional Offices.

To determine if VISTA access was appropriate for the 376 individuals who were associated with CCHCS but who were not employees, we reviewed the need for VISTA access for 15 individuals. We found that 5 of the 15 individuals (4 residents and 1 consulting and attending physician) worked at the CCHCS and required VISTA access. The remaining 10 individuals were no longer associated with the CCHCS and should have had their access deactivated (4 were former employees, 4 were residents or students who no longer worked at the CCHCS, and 2 were former contract employees). IRM managers stated that VISTA access had not been deactivated

promptly because service chiefs did not always respond to IRM requests to update VISTA access needs for their services. To ensure that access is deactivated promptly, CCHCS management should re-emphasize to service chiefs the importance of promptly notifying IRM when anyone in their service no longer requires access.

To determine if VISTA access was needed for the 195 individuals from other VA facilities, we reviewed access patterns for all 195 individuals. We found that 115 of the 195 individuals had not accessed VISTA in the past 90 days, 75 had not accessed VISTA for at least 15 months, and 68 had never accessed VISTA. IRM managers told us that their attempts to verify the continued need for VISTA access for individuals from other VA facilities had not been successful. To address this problem IRM should simply deactivate access for users who have not logged on to the system for a specified period of time.

Contingency Plans. VHA facilities are required to develop and implement information system contingency and recovery plans. The plans should be designed to reduce the impact of disruptions in services, to provide critical interim processing support, and to resume normal operations as soon as possible. The plans should also prioritize mission-critical information systems and identify the resources needed to support each system. We concluded that the CCHCS contingency plan effectively addressed most issues. However, the plan did not include a detailed prioritization of mission-critical systems or a designated alternative processing facility.

- **Prioritization of Critical Systems.** The plan identified four major systems -- VISTA, the Automated Engineering Management System/Medical Equipment Management System, the Administrative/Clinical Microcomputer Based System, and the Telecommunications System. The plan prioritized VISTA as the most critical system but did not prioritize the other three systems. In addition, the plan did not prioritize the individual applications within VISTA, which includes more than 100 different applications that support various clinical, financial, and administrative activities. If a disaster occurred that resulted in a limited or phased recovery, the absence of a detailed plan prioritizing the individual VISTA applications and the other three major systems would force CCHCS managers to prioritize the systems after the disaster, which could delay the restoration of some critical systems.
- **Designation of an Alternative Processing Facility.** The contingency plan did not include a designated alternative processing facility that could provide backup to AIS services in the event that the primary facilities are severely damaged or could not be accessed.

We concluded that the CCHCS Director needed to ensure that (a) VISTA access is deactivated promptly for all individuals who do not have a continued need for access; (b) the CCHCS contingency plan includes a prioritization of the VISTA applications and the other major critical systems; and (c) the CCHCS contingency plan designates an alternative processing site. The Director agreed and reported that on May 15, 2000, the CCHCS implemented a system that monitors staff needs for access to VISTA and assures immediate termination of access for individuals that do not need access. In addition, as of June 1, 2000, the contingency plan had been revised to prioritize mission critical systems and designate an alternative processing facility. The corrective actions are acceptable and we consider the issue to be resolved.

Controlled Substances Inspections -- Expired Drugs Should Be Inspected

We reviewed controlled substance inspections to determine if they ensured that all controlled substances were properly accounted for. VHA facilities are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The inspectors must be VA employees who do not work in the Pharmacy Service. Inspectors should physically count the quantities of controlled substances on hand and reconcile these quantities to perpetual inventory records. We requested and observed an unannounced inspection of selected areas where controlled substances were stored and dispensed. We also reviewed records of the inspections done for the 14-month period February 1999 through March 2000. Both our unannounced inspection and the prior inspections found good accountability for controlled substances.

We noted only one inspection issue -- inspection procedures did not cover excess, outdated, or unusable controlled substances that were stored in the pharmacy vault until they could be destroyed. VHA policy requires that inspections include these drugs (VHA Handbook 1108.2). To ensure independent oversight of stored drugs and to comply with VHA policy, these drugs should be included in the monthly inspections. Pharmacy management agreed that this would be required on future inspections.

We concluded that the CCHCS Director needed to ensure that excess, outdated, and unused controlled substances are included in monthly inspections. The Director agreed and reported that as of May 26, 2000, controlled substances inspection policies had been changed to include expired drugs in all inspections. The corrective action is acceptable and we consider the issue to be resolved.

Accounts Receivable -- Reconciliations Should Be Performed and Delinquent Debts Should Be Pursued

VA policy requires that accounts receivable owed to VHA facilities be accurately recorded in accounting records, reconciled to VA's general ledger each month, and collected promptly. To ensure that accounts receivable are accurate, each month Financial Management staff should reconcile the amounts shown as billed, paid, and owed in the CCHCS Integrated Fund Control Point Activity Accounting and Procurement System (IFCAP) with the general ledger amounts shown in VA's Financial Management System (FMS). In addition, at least once each quarter Financial Management staff should review the "Verification of General Ledger Balances -- Accounts Receivable" report to identify receivables that are more than 90 days old. These delinquent receivables should be analyzed to determine whether they should be pursued or written off. During our review, Financial Management staff acknowledged that they had not performed either the monthly reconciliations or the quarterly reviews for at least 3 years. As a result, delinquent receivables had not been identified and aggressively pursued.

Monthly Reconciliations. Financial Management staff stated that the IFCAP and FMS monthly reports that would normally be used to perform the accounts receivable reconciliations had been routinely printed but had not been reconciled. To assess the accuracy of the reported accounts receivables, we compared the February 2000 IFCAP and FMS reports. We found that the two reports did not agree. The IFCAP report showed a value of \$280,948 and the FMS report

showed a value of \$252,290. The comparison also found that: 73 receivables (value = \$79,292) were reported in IFCAP but not in FMS; 5 receivables (value = \$4,391) were reported in FMS but not in IFCAP; and 1 receivable was valued at \$3,916 in IFCAP and \$1,664 in FMS. When we discussed these results with Financial Management officials, they acknowledged that neither the IFCAP nor the FMS reported totals reflected the correct receivables amount. Because Financial Management had not reconciled the IFCAP and the FMS reports they could not identify and pursue the collection of all delinquent receivables.

Pursuing Delinquent Receivables. During our review Financial Management staff acknowledged that they had not been consistently identifying and pursuing delinquent receivables. Because IFCAP and FMS reconciliations had not been done we could not determine the precise value of the total receivables. However, relying on the unreconciled IFCAP reports, we determined that as of March 2000, the CCHCS had 52 vendor receivables valued at \$227,402. Of these, 47 with a value of \$155,465 were more than 90 days old.

In January 2000, a VHA Financial and Systems Quality Assurance Review team visited the CCHCS to review the Medical Care Cost Fund Program. Among other exceptions, the team found that the CCHCS Financial Management staff was not aggressively pursuing collection of receivables. As a result of the VHA review, 43 of the 47 receivables were referred to the VA Regional Counsel for enforced collection.

The VHA team also recommended that the CCHCS write off 21 other old receivables as uncollectible. These receivables had been written off at the time of our review. The dates of these receivables ranged from April 1993 to March 1998. The team concluded that the receivables were not collectable because some of the supporting documentation had been lost and some had been destroyed during a 1996 storm that caused the collapse of the roof on the building where the documents were stored. During January and February 2000 Financial Management staff wrote off the 21 old receivables valued at \$21,207. If the CCHCS had established effective controls to aggressively and promptly pursue debts the old receivables might have been collected before the documentation was lost or destroyed.

Although most of the old receivables with collection potential had been referred for enforced collection, as of March 2000 the CCHCS had not established the internal processes needed to identify and aggressively pursue delinquent receivables. To illustrate, during our review we identified four receivables that were older than 90 days. The dates of the four receivables ranged from February 1998 to November 1999. We reviewed the collection potential of the four receivables and concluded that three (value = \$1,385) had not been pursued aggressively for collections. Financial Management staff had sent collection letters, but had not called the vendors to determine why payment had not been made.

To improve the collection of accounts receivable the CCHCS Director needed to ensure that Financial Management staff (a) perform monthly reconciliations of IFCAP and FMS accounts receivable and (b) establish controls for identifying and pursuing delinquent receivables. The Director agreed and reported that as of June 15, 2000, additional staff had been hired and a system had been implemented so that monthly reconciliations can be performed and delinquent accounts receivable can be better pursued. The corrective actions are acceptable and we consider the issue to be resolved.

Medical Care Cost Fund – Signed Means Test Forms Should Be Obtained

The CCHCS needed to improve procedures for obtaining signed means test forms from veteran-patients. As part of VA Medical Care Cost Fund requirements, copayments are collected from certain patients to offset the costs of treatment provided for nonservice-connected conditions. Patients with income below certain thresholds are exempted from these copayments. Each year patients who may be subject to copayments must provide updated income information by signing a means test income verification form. The patient's reported income is entered into a national eligibility database that is verified with Social Security and Internal Revenue Service (IRS) records. If a patient is required to make a copayment but does not, VHA facilities may collect the copayment from IRS refunds that are owed to the patient. However, income verification and collections from IRS refunds can only be accomplished if the patient's means test form is signed.

During the 5-month period October 1999 through February 2000, CCHCS's Business Administration Service (BAS) processed 118 means test cases in which patients reported zero income and 435 means test cases in which patients reported more than one dependent. We selected a judgmental sample of 50 cases (30 zero income cases and 20 more than one dependent cases) and requested that BAS staff provide us with the administrative file for each case. BAS staff could only find 40 of the requested administrative files. BAS managers told us that the remaining 10 files could not be located because file maintenance had become a low priority because of staffing shortages.

We reviewed the 40 administrative files and found that 15 (37.5 percent) did not include a signed means test verification form. If a signed form is not on file, the CCHCS cannot verify the patient's income information and unpaid copayments cannot be collected from IRS refunds. According to BAS management, all means test forms did not include patient signatures because key staff did not understand the importance of obtaining signatures and because staffing shortages made it difficult to ensure that all forms were signed.

We concluded that the CCHCS Director needed to ensure that (a) BAS staff organize all patient administrative files so that they can be quickly located and (b) BAS staff receive refresher training emphasizing the importance of obtaining signed means test forms. The Director agreed and reported that as of June 1, 2000, refresher training had been provided to all affected employees. In addition, a file system for the medical records would be in place by August 15, 2000. The corrective actions are acceptable and we consider the issue to be resolved.

Fraud and Integrity Awareness Briefings

As part of the CAP review, Office of Investigations agents conducted four 90-minute Fraud and Integrity Awareness briefings, which included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. About 120 CCHCS employees attended the briefings. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1 delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Management is required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that is not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, Division staff assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or a criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the Division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, overbilling, false claims, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, Compensation and Pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of

interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** -- Names, position titles, connection with VA, and other identifiers.
- **What** -- The specific alleged misconduct or illegal activity.
- **When** -- Dates and times the activity occurred.
- **Where** -- Where the activity occurred.
- **Documents/Witnesses** -- Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

To report suspected wrongdoing in VA programs and operations, call the OIG Hotline -- (800) 488-8244.

CCHCS Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 6, 2000

From: Director, Central California Health Care System (00/570)

Subj: Response/Action Plan to IG CAP Report (Project No. 2000-1227-R8-230)

To: Assistant Inspector General for Auditing (52)

1. I have thoroughly reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the VA Central California Health Care System. I concur with the findings and eight recommendations and have provided an action plan for resolution.
2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

(Original signed by:)
Alan S. Perry
Director

Central California Health Care System: IG CAP Implementation Plan

Subject	Corrective Actions	Target Completion Date
<p>Contract Nursing Home</p> <p>A. Contract Nursing Homes are inspected every year.</p> <p>B. Inspections are thorough and include follow-up on the corrections on identified deficiencies.</p>	<p>A. & B.:</p> <ol style="list-style-type: none"> 1. A revised policy had been completed and implemented that adheres to the Directive. 2. An inspection team was formed to include; Nurse Manager, Social Worker, Pharmacist, Safety, and Contracting Officer. 3. All inspections have been performed and any deficiencies have been corrected. 4. The team will inspect yearly. 	<p>A.& B.: Completed</p>
<p>Medical Information</p> <p>A. Complete medical records more promptly.</p> <p>B. Reduce the backlog of unfiled medical record documents. (loose filing was at 45 feet, of which 30% was duplicated on the computer)</p> <p>C. Ensure that medical records are securely stored (specific to clinic areas).</p>	<ol style="list-style-type: none"> 1. Just prior to survey a revised policy was written. This included a pink and red letter notification system to the physicians. 2. Medicine and Surgery Services have assigned a staff person accountable to track physicians medical record completion. 3. The data for the first month have resulted in a reduction to 37% delinquent rate from greater than 50%. <ol style="list-style-type: none"> 1. Staff overtime approved. 2. 2.0 Temporary FTEE staff hired. 3. Proposal to Medical Records committee to stop filing duplicative electronic notes (except inpatients). <ol style="list-style-type: none"> 1. Exam area records to be picked up by staff and returned to baskets throughout the day. 2. Wall pockets to hold records at the exam room are to be purchased and mounted for added security and privacy. 3. File room staff to pick up all baskets at days end with the hiring of 2.0 FTEE. 	<ol style="list-style-type: none"> 1. significant improvement; final resolution 8/15/00. <ol style="list-style-type: none"> 1. 9/30/00 <ol style="list-style-type: none"> 1. 6/19/00 2. 7/15/00 3. 7/31/00

Subject	Corrective Actions	Target Completion Date
<p>Pt. Care Environment, Staff, Scheduling</p> <p>A. Patient Care Environment:</p> <ol style="list-style-type: none"> 1. Staff expressed concern about cleanliness. 2. Equipment in hallways; inpatient unit. <p>B. Pharmacy Service staffing shortage.</p> <p>C. Staffing issues raised by employees.</p> <p>D. Waiting times for scheduling clinic appointments (primary care, urology, neurology).</p> <p>E. Patient and Employee survey results.</p>	<ol style="list-style-type: none"> 1. Organizational priority; integrated plan ongoing with daily supervision and monitoring. 2. Complete re-model of the inpatient ward to include significant storage. 3. Alternative temporary site for storage located one floor above. <ol style="list-style-type: none"> 1. Extensive planning and recruitment ongoing. Hired 3.0 FTEE Pharmacists, 3.0 FTEE Pharmacy aides. 2. Perform salary survey. <ol style="list-style-type: none"> 1. Daily monitoring of staffing and patient needs. 2. Recruitment/retention strategies developed for difficult to staff areas. <ol style="list-style-type: none"> 1. Implemented the IHI waits and delays system in primary care (currently 32 days). 2. Targeting same system for specialty clinics beginning with urology. <ol style="list-style-type: none"> 1. Customer service plan which includes 17 specific targets has been written and a manager hired. 2. Revised employee recognition program has been completed with ongoing implementation. 3. Union and Management partnership fully implemented. 	<ol style="list-style-type: none"> 1. completed, ongoing 2. 2/1/01 3. 5/15/00; completed <ol style="list-style-type: none"> 1. 8/1/00 2. 6/15/00 <ol style="list-style-type: none"> 1. ongoing 2. 6/1/00 <ol style="list-style-type: none"> 1. 5/15/00 2. 9/1/00 <ol style="list-style-type: none"> 1. Plan completed, full implementation by 9/30/00. 2. 8/1/00 3. completed
<p>Management Controls</p> <p>A. Automated inventory controls are to be effectively used to reduce engineering and medical supply inventories to levels consistent with current needs.</p> <p>B. Warehouse inventories do not include supplies stocked by SPD.</p>	<p>A. & B.</p> <ol style="list-style-type: none"> 1. Implement Item Master File. 2. Training to build GIP system architecture. 3. Implement GIP in Warehouse and SPD. 4. Implement manual inventory system in Engineering. 	<ol style="list-style-type: none"> 1. 8/1/00 2. 7/15/00 3. 11/1/00 4. 8/15/00

Subject	Corrective Actions	Target Completion Date
<p>Information Technology Security</p> <p>A. VISTA access is to be promptly deactivated for all individuals that do not have a continued need for access.</p> <p>B. Contingency plan to include a prioritization of the VISTA applications and other major applications.</p> <p>C. Contingency plan designates an alternative processing site.</p>	<p>1. System implemented to monitor staff need for access in conjunction with Human Resources, Quality Management (credentialing), Fiscal (PAID system) to assure immediate termination of VISTA.</p> <p>1. Revise contingency plan to include these parameters.</p> <p>1. Plan revision included an alternative processing site which could provide backup to AIS in the event our primary site became damaged or could not be accessed.</p>	<p>1. 5/15/00, completed</p> <p>1. 6/1/00, completed</p> <p>1. 6/1/00, completed</p>
<p>Controlled Substance Inspections</p> <p>A. Ensure that excess, outdated, and unused controlled substances in the monthly inspections.</p>	<p>1. Policy changed and implemented at the time of the survey.</p>	<p>1. completed</p>

Subject	Corrective Actions	Target Completion Date
<p>Accounts Receivable</p> <p>A. Perform monthly reconciliations of IFCAP and FMS accounts receivables.</p> <p>B. Establish controls for identifying and pursuing delinquent receivables.</p>	<p>1. Approval/hire increases Business Administration staff.</p> <p>2. System for monthly reconciliations implemented.</p> <p>1. Hire additional staff.</p> <p>2. System designed/implemented to collect, refer, or write-off receivables greater than 3 months.</p> <p>3. Process designed and implemented for collection to average 35 days.</p>	<p>1. 6/1/00, completed</p> <p>2. 6/1/00</p> <p>1. 5/15/00, completed</p> <p>2. 6/1/00, completed</p> <p>3. 6/15/00</p>
<p>Medical Care Cost Fund</p> <p>A. BAS staff organize all patient administrative files so that they can be quickly located.</p> <p>B. BAS staff receive refresher training emphasizing the importance of obtaining signed means test.</p>	<p>1. Medical records administrator to design/implement file system to include all administrative files.</p> <p>1. Training completed for all involved BAS staff. Refresher training is scheduled every 3 months.</p> <p>2. VISTA patch implemented which will now alert staff when a Means Test is required.</p>	<p>1. 8/15/00</p> <p>1. 6/1/00, completed</p> <p>2. 5/15/00, completed</p>

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