Department of Veterans Affairs

Office of Inspector General

COMBINED ASSESSMENT PROGRAM REVIEW
Carl Vinson VA Medical Center, Dublin, GA

Report No: 00-00358-44
Date: March 20, 2000

Office of Inspector General
Washington DC 20420

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 administrative and financial 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.

Executive Summary

Combined Assessment Program Review

Carl Vinson VA Medical Center, Dublin, GA

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Carl Vinson Department of Veterans Affairs Medical Center (VAMC), Dublin, GA. The purpose of the review was to evaluate selected clinical and administrative operations, focusing on the quality of care delivered and the effectiveness of management controls. We also provided fraud and integrity awareness training to medical center employees. In addition, a review of hotline allegations that had congressional interest was initiated.

2. VAMC Dublin is a 93-bed primary and secondary care facility, providing medical, surgical, psychiatric, and rehabilitative services. The medical center also operates a 103-bed nursing home care unit, and a 145-bed domiciliary that includes a 35-bed homeless veterans program. In addition, the facility operates community based outpatient clinics (CBOCs) in Albany and Macon, GA.

3. For Fiscal Year (FY) 1999, the medical center's budget was about $60 million. Additionally, the medical center had accumulated a balance of over $5 million in its Medical Care Collections Fund. The medical center employed 726.4 full time equivalent employees. During FY 1999, 2,026 medical care inpatients, 168 nursing home patients, and 488 domiciliary patients were treated. The medical center also provided a total of 115,710 outpatient visits, of which 7,879 were provided at the Albany CBOC and 8,618 at the Macon CBOC.

4. The OIG CAP team visited VAMC Dublin from November 15 to 19, 1999. Part I of this report provides more detail on the organizational structure of the medical center, and the purpose, scope, and methodology of the CAP review. Part II contains the results of the CAP review and includes recommendations to enhance patient care and strengthen management controls. The following are highlights of our observations and results, including areas that appear vulnerable and are in need of greater management attention:

- Patient Care and Quality Management – While we found that the medical center had a comprehensive quality management program in place, we identified some opportunities to further enhance its effectiveness. We also identified several issues that required increased management attention to ensure high quality patient care. These issues include: the quality and documentation of inpatient treatment goals and discharge plans; management and oversight of the domiciliary program; implementation of a structured and therapeutic Post Traumatic Stress Disorder (PTSD) program

to effectively reduce the anxiety and address the dissatisfaction of PTSD patients; and monitoring of intermittent staffing shortfalls and filling of vacant physician and nursing positions. For details and recommendations to improve operations see Part II.

- General Administrative and Management Control Issues - Overall the medical center maintained an effective system of financial management controls. For most controls tested, we identified only minor deficiencies. Areas reviewed which require greater management attention include: reducing excess inventory costs of medical supplies; reducing the lag time for billing third-party insurers; and improving the documentation of means tests. We also concluded that management needed to address employees' concerns and perceptions about the quality of patient care, the work environment, and personnel management practices in order to enhance morale. For details and recommendations to improve operations see Part II.

- Fraud and Integrity Awareness Briefings – Medical center staff were briefed on recognition of fraudulent situations, referral of issues to the Office of Investigations, and the type of information needed to make a complaint referral. For more details see Appendix I.

- Hotline Allegations – An administrative investigation concluded that hotline allegations referred to the OIG were not substantiated. The results of that investigation will be addressed in a separate report.

5. The Medical Center Director concurred with the recommendations and provided acceptable implementation plans. We consider the issues resolved. The OIG may follow-up at a later date to evaluate the corrective actions taken.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

Table of Contents

Page

Executive Summary i

PART I – INTRODUCTION

A. Purpose 1
B. Scope and Methodology 1
C. Background – Medical Center Operations 2

PART II – RESULTS AND RECOMMENDATIONS

A. Management Opportunities to Improve the Delivery and Quality of Patient Care Services 3

B. Opportunities to Further Improve Management Controls and Enhance Employee Morale 14

Appendix I – Fraud and Integrity Awareness Briefings 26

Appendix II – Medical Center Director's Comments 29

Appendix III – Report Distribution 30

PART I

INTRODUCTION

A. Purpose

The purpose of a Combined Assessment Program (CAP) review is to help management by identifying opportunities for improvement, and help prevent fraud, waste, and abuse. See the inside cover for a full description of a CAP review.

B. Scope and Methodology

We reviewed numerous quality assurance documents and over 90 patient medical records. We also inspected the physical environment of all inpatient and outpatient treatment facilities at the medical center. Using structured survey instruments, we interviewed and analyzed the results of responses from 15 clinical managers, 15 clinicians, and 51 patients. Additionally, we distributed questionnaires to 142 randomly selected full-time employees. The questionnaire return rate was 80/142 (56 percent). Results were summarized and shared with medical center management. We met with all employees and patients who requested a visit with the OIG team to raise their concerns and complaints - 53 employees and 54 patients. In addition, we reviewed the following patient care and quality management areas:

Acute Care Medicine and Surgery
Community Based Outpatient Clinic Ops.
Domiciliary Program
Substance Abuse Treatment Program
Homeless Veterans Program
Compensated Work Therapy Program
Ambulatory Care Services
Clinician Staffing
PTSD Program
Geriatrics and Extended Care
Physical Med. & Rehab. Service
Physical Therapy
Occupational Therapy
Palliative Care
Quality Management Program
Informed Consent
Prescribing Practices for Elderly

Our review of general administrative and financial control issues involved analysis of medical center operational performance reports and statistics, and review of selected medical center administrative activities and internal controls. Specifically, we assessed: agent cashier controls, funds management, purchase card controls, timekeeping controls, debt collection, beneficiary travel controls, expendable and non-expendable inventory controls, accuracy of means testing, Medical Care Collections Fund (MCCF) billing procedures, follow-up on insurance claims denials, ADP procurements, and Y2K status of medical equipment. Additionally, we analyzed the results of employee questionnaires

and interviews, including those of walk-in staff and patients, to identify issues and concerns that required greater management attention.

In an effort to enhance medical center employees' awareness of fraud and understanding OIG's role in investigating indications of fraud, we conducted 4 fraud and integrity awareness briefings to over 170 employees. Additionally, an administrative investigation was initiated in response to a congressional complaint regarding a number of allegations. These allegations were found to be unsubstantiated and will be addressed in a separate report.

C. Background – Medical Center Operations

The Carl Vinson VA Medical Center (VAMC Dublin) is located on a 175-acre landscaped tract in Dublin, GA, and is the largest healthcare facility in the community. VAMC Dublin is a 93-bed primary and secondary care facility, providing medical, surgical, psychiatric and rehabilitative services. The medical center also operates a 103-bed nursing home care unit, and a 145-bed domiciliary that includes a 35-bed homeless veterans program. In addition, the facility operates community based outpatient clinics (CBOCs) in Albany and Macon, GA. The medical center's traditional primary service area covers 52 counties in south central Georgia. The primary referral centers for tertiary care are VAMC Augusta and VAMC Atlanta.

For Fiscal Year (FY) 1999, the medical center's budget was about $60 million. Additionally, the medical center had accumulated a balance of over $5 million in its MCCF which was not obligated at the time of the OIG's visit. During FY 1999, the medical center employed 726.4 full time equivalent employees, and treated 2,026 medical care inpatients, 168 nursing home patients, and 488 domiciliary patients. The medical center also provided a total of 115,710 outpatient visits, of which 7,879 were provided at the Albany CBOC and 8,618 at the Macon CBOC.

Several new patient care programs were recently initiated at the medical center. These include; opening the Macon and Albany CBOCs in August 1998, beginning a compensated work therapy program in March 1999, and dedicating a Post Traumatic Stress Disorder Treatment (PTSD) Center (PTC) in April 1999.

PART II

RESULTS AND RECOMMENDATIONS

A. Management Opportunities to Improve the Delivery and Quality of Patient Care Services

We concluded that the medical center had a comprehensive quality management (QM) program. While we found that appropriate monitors were in-place and effectively working, we identified some opportunities to further improve the effectiveness of focused reviews/Root Cause Analyses, CBOC incident reporting, and prescription practices for the elderly. Our review of medical center operations also identified several issues that required increased management attention. These include the quality and documentation of inpatient treatment goals and discharge plans; the management and oversight of the domiciliary program; the implementation of a structured and therapeutic PTSD program to effectively reduce the anxiety and address the dissatisfaction of PTSD patients; and more closely monitoring intermittent staffing shortfalls and filling vacant physician and nursing positions. Areas requiring greater management attention are discussed more fully below.

Results

Opportunities to Further Enhance Quality Management

We concluded that VAMC Dublin has a comprehensive QM program that includes national and local performance measures, risk management, utilization management, peer review and occurrence screening. Some specific areas we reviewed include: informed consent, delivery of ambulatory care services, incident reports, Boards of Investigations and Root Cause Analyses, and prescription practices for the elderly. As discussed below, reviewed areas were generally operating effectively, however, several issues were identified that should be addressed or followed-up by management.

Informed Consent

Informed consent is a process to promote "informed" decision-making by the patient. It defines the obligations and duties of the healthcare staff in assuring that the patient is given sufficient information to make an informed decision concerning the available treatment options. To ensure that each patient's informed consent is properly documented in the medical record, an informed consent progress note must be made by the practitioner. In addition to the progress note, a statement must be included indicating that risks, benefits, and

alternative options have been discussed with the patient in language the patient understood, as well as a statement that the patient had an opportunity to ask questions and indicated comprehension of the discussion. Other items that must be documented include that patient's mental status at the time the information was given, and the practitioner's assessment of whether the patient has decision-making capacity.

We found that the facility developed a form to capture all required information, and the form was consistently completed. The practitioner checked off all appropriate blocks and signed the form. This form was attached to the request for anesthesia form, which was witnessed and signed by the patient. We concluded that the facility's informed consent process was well organized and effective at documenting informed consent discussions.

Ambulatory Care Services

The Veterans Health Administration (VHA) is currently emphasizing primary care and outpatient care for all veterans. To provide primary care, all veterans should be assigned to a primary care team provider. Quality outpatient care should include: timely scheduling of consults, laboratory tests, imaging tests, and follow-up visits; providing flu and pneumonia vaccinations when requested; and dispensing drugs as prescribed.

To assess the quality of care provided by VAMC Dublin, we randomly sampled 30 outpatient visits that occurred during the week of October 18, 1999 and 11 outpatient surgical procedures from the month of September 1999, relating to 37 unique veterans. We found that all 37 veterans were assigned to a primary care team. According to the medical records, 6 consultations, 22 tests, and 26 follow-up visits had been ordered, 5 vaccinations had been requested, and 19 drugs had been prescribed for these 37 veterans. We found that all 6 consultations had been promptly completed or scheduled, all 5 vaccinations had been given the same day requested, and all 19 drugs had been dispensed. However, we found that 1 of the 22 tests (5 percent) and 2 of the 26 follow-up visits (8 percent) had not been accomplished or scheduled.

We concluded that VAMC Dublin is succeeding in switching to primary care and has a good system to ensure that required care is provided in a timely manner. However, some improvement is needed to ensure that all tests and follow-up visits ordered by providers are scheduled.

Incident Reports

FY 1999 Reports of Special Incident Involving a Beneficiary were reviewed. The incidents were appropriately reported and acted upon. The facility has designed and implemented a medical center-wide anonymous patient incident reporting system. This process has increased incident reporting by 90 percent. The

facility plans to use this database to develop mechanisms to reduce incidents and adverse outcomes. The focus in FY 2000 is to reduce the occurrence of patient falls.

We were informed that incident reporting at the CBOCs appears to be based on the unilateral decision of the CBOC program manager, and may not be in accordance with guidelines followed by the parent facility. The program manager acknowledged that he determines whether an incident is severe enough to report, and if so, the proper procedures are followed. The subjective nature of the reporting, however, may lend itself to inconsistency in terms of reportable incidents across the parent facility and CBOCs. Reporting of all incidents, with subsequent review by appropriate staff, would resolve the issue and better ensure the accuracy and reliability of the medical center's database.

Boards of Investigation (BOIs) and Root Cause Analyses (RCAs)

We reviewed 12 BOIs and 13 focused reviews/RCAs for FY 1999. The conclusions, corrective actions, and follow up assessments associated with the BOIs were consistent with the investigative findings. However, the quality of focused reviews/RCAs was inconsistent and often inadequate to provide useful or meaningful information to identify, or to effect correction of, causative or contributory factors. Team membership may contribute to the questionable quality of a review, particularly if the team was made up of individuals who were involved in the care process at the time of the occurrence. Time factors may also impact the quality of review, particularly when the team members have limited time to be away from patient care. The risk manager is aware of the situation and plans to commit one staff member to focused reviews/RCAs and patient safety processes. Management should support this effort and monitor progress.

Prescribing Practices for the Elderly

The management of prescription drugs is an issue that has drawn a significant amount of attention especially for elderly patients aged 65 and older. The elderly take more prescription drugs than any other age group and more often take several drugs at one time, which increases the probability of adverse drug reactions. Health care providers report that the elderly are also more vulnerable to adverse drug reactions as they often do not eliminate drugs from their systems as efficiently as younger patients because of decreased liver and kidney function. As a result, some drugs can impair their physical or mental functions or even cause hospitalization or death.

In 1991, geriatric experts identified 20 drugs that are considered inappropriate for use by elderly patients because alternative drugs provide equivalent therapeutic benefits with fewer side effects. We reviewed three of these drugs that were on the VAMC Dublin formulary - Amitriptyline, Propoxyphene, and Dipryamole and found that they were regularly prescribed to the elderly.

Many clinicians maintain that use of these drugs is appropriate if the patient is doing well on the drug and is closely monitored. We concluded that a monitoring system existed for inpatients, but it was unlikely that all outpatients were being closely monitored. Accordingly, we believe that all prescriptions for the three drugs to patients 65 years old or older, should be reviewed to determine if drugs with fewer side effects should be prescribed. If it is determined that elderly patients should remain on these drugs, they should be closely monitored to reduce the chance for severe side effects.

Medical Records Documentation of Patient Services Should Be Improved

We reviewed 41 randomly selected medical records of inpatients who were occupying acute (13), long-term (13), or domiciliary (15) beds during the time of our visit. The purpose of this review was to assess the quality of documentation of treatment plans, problem lists, consultations, and discharge planning. We concluded that medical record documentation needed improvement in a number of areas.

Medical record reviews of acute care patients showed that treatment plans were absent in 5 of 13 (38.5 percent) records. Only 5 of the 8 records that contained treatment plans documented all identified patient care issues. Further, only 6 of 13 (46.2 percent) records contained a current problem list. All 13 records had consults ordered, and all but 1 consultation was completed within 1 working day. While most records documented some level of discharge planning, we observed that the documentation was often incomplete and inconsistent, forms and flow sheets were difficult to follow, and documentation of reassessment of patient care needs and revision of treatment goals were inadequately documented.

Medical record reviews of 13 long term care patients showed that quarterly discharge plans were not always documented. Documentation of quarterly planning was missing in 3 of 13 records reviewed (23.1 percent). We also noted that the discharge planning policy for patients meeting palliative care criteria may need clarification to include circumstances when it would be appropriate to continue discharge planning for certain palliative care patients.

Medical record reviews of 15 domiciliary patients showed that generally, initial interdisciplinary treatment plans were completed in a timely manner and reflect participation and concurrence of the interdisciplinary treatment team members. We found, however, that although proposed discharge dates were recorded, in 6 of the 15 charts reviewed (40 percent) the actual discharge was deferred. Further, in four of these six cases, it was found that the patient was not meeting the established goals but no updated treatment plan could be located. In some instances, the reason for extending the patient's stay in domiciliary care was not always clear, nor was there consistent documentation regarding the therapeutic goals to be achieved during the extended stay. We also noted that treatment plans of domiciliary residents, who were not participating in either the homeless

veterans or substance abuse programs, generally had cursory treatment plans, leaving patients with an excessive amount of unstructured time. (This issue is more fully discussed in the domiciliary section below.)

Conclusion A cross section of inpatient medical records showed that documentation of treatment plans, problem lists, and discharge plans needed improvement.

Recommendation 1 The Medical Center Director should require clinical staff to conduct periodic reviews of inpatient medical records to identify and correct deficiencies in patient's medical records and ensure the quality of patient care treatment.

Medical Center Director's Comments

We concur with this recommendation and will implement the following actions to correct deficiencies.

Quarterly reports will be submitted to the Primary Care Service Line Manager and MEC. Target Date: March 2000

A multidisciplinary medical records team of the Information Management Committee (IMC) has been charged with the responsibility for monitoring and improving the quality of medical record documentation within the facility. The team will redesign the medical record review process and review criteria. Each service line will establish a medical record workgroup. These workgroups will conduct focused reviews of medical records using service line specific criteria (all workgroups will include measures of quality documentation of treatment plans, and effectiveness of goal achievement). Quality Management staff will facilitate the work of the groups. The findings and recommendations will be reported quarterly to the Service Line Quality Leadership Team, IMC, Executive Leadership Team and Medical Executive Committee. Target Date: FY 2000

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

Domiciliary Housing and Program Concerns

Management needs to improve the overall quality of the housing and patient care of domiciliary residents. We toured each unit of the domiciliary and interviewed employees and numerous patients regarding the cleanliness, maintenance, security, and safety of housing for domiciliary patients. We concluded that while some recent efforts had been made, there was a need to conduct a thorough top

to bottom cleaning of all domiciliary units. Routine maintenance had not been done in months, and staff informed us that maintenance and repair orders submitted months ago had not been completed. We also observed that much of the bedding and furniture was in poor condition and needed repair or replacement, and that electric-fuse/breaker boxes were not secured representing a safety hazard to patients and employees. Patients also complained about a lack of privacy, and that the heating and cooling of some domiciliary units was not well regulated. Many of the 30 domiciliary patients who spoke to us complained that there was no means for them to express their concerns to medical center management about inadequate mental health programs, poor communications with hospital staff, and lack of cleanliness and recreational facilities in the domiciliary.

We concluded that due to the gradual loss of staff over the past several years and an apparent lack of supervision and management oversight, sufficient resources were not provided to maintain the physical plant and help domiciliary patient-residents achieve therapeutic goals. For example, we found that the "general" population of domiciliary patient-residents was more likely to have cursory treatment plans, an excessive amount of unstructured time, and more likely to obtain extensions to planned discharge dates, than homeless veterans program patient-residents. Additionally, facility statistics show that about 40 percent of domiciliary discharges were irregular (against doctor's orders), but there was no local policy or guidelines addressing irregular discharges, readmissions, or study of recidivism and its relationship to irregular discharges and the quality of discharge planning. We also observed that by expanding the compensated work therapy program, more training and work opportunities could be offered to the general population of domiciliary residents.

Conclusion The domiciliary program should be given closer supervision and management oversight to improve patient living conditions, assure patient safety, and better ensure the quality and effectiveness of care provided.

Recommendation 2 The Medical Center Director should develop and implement a plan of action to ensure patient living conditions are improved and the quality and effectiveness of care provided to domiciliary patients is enhanced. Implementation plans should correct deficiencies noted by the CAP team and include strategies to:

- Improve the cleanliness, maintenance, safety, security and overall quality of housing for domiciliary patients.

- Conduct quality management focused reviews to evaluate the quality of patient treatment plans, ensure domiciliary residents are achieving therapeutic goals, determine the causes and identify opportunities to reduce the number of irregular discharges, recidivism, and inappropriate readmissions.

- Conduct a management review to determine staffing and recurring funding needs to more sufficiently maintain, furnish, and supervise the domiciliary program.

- Conduct periodic meetings with, and/or develop resident questionnaires to identify and respond to domiciliary residents' concerns and complaints.

Medical Center Director's Comments

We concur with this recommendation and will implement the following actions to correct deficiencies.

A Compensated Work Therapy (CWT) program has been finalized that will ensure that six additional staff can be assigned to housekeeping functions and assist in overall cleaning of these areas. Housekeeping staff will be supplemented with CWT employees and Environmental Management Section staff and Primary Care supervisors will provide oversight. We will continue to monitor via our Environmental Rounds Team.

The door closure policy for the Medical Center is being revised to ensure designated doors are locked at all times and time schedules are maintained for doors to be secured after normal operating hours. Police/Security will be responsible for ensuring that security is maintained and door policy is enforced. Target Date: March 2000

Primary Care and Operations Service Lines will present a joint proposal for renovation of the Domiciliary. Target Date: September 2000

Primary Care Business Manager is identifying furniture that is appropriate for the domiciliary and funding is available for the items selected. Target Date: April 2000

Primary Care Service Line's medical record workgroup will conduct focused and ongoing medical record reviews using predetermined criteria. Quality Management staff will facilitate the work of the group. Target Date: March 2000

Quarterly reports will be submitted to Quality Leadership Team (QLT) and Medical Executive Committee (MEC). Target Date: March 2000

We will charter a process improvement team to study admissions and discharge processes to the domiciliary. The issues of irregular discharges, recidivism, and inappropriate readmissions will be addressed. Target Date: May 2000

Primary Care Manager will schedule quarterly domiciliary resident meetings that the Triad and appropriate staff will attend. The Domiciliary Council will be reinstated. The Primary Care Manager will complete a Domiciliary Resident

Needs Assessment/Satisfaction Survey. This will be accomplished by Target Date: March 2000

Funding has been approved for a Domiciliary Coordinator and recruitment is ongoing and expected to be completed by May 2000.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

PTSD Patient and Program Concerns

The medical center announced that on April 30, 1999, it had dedicated a new Post Traumatic Stress Care Team (PTC.) The medical center reportedly received funding for a PTC a few years ago, yet the program was never officially started. In the interim, a psychiatrist assigned to mental health has for a number of years worked almost exclusively with PTSD patients, many of whom are members of the Combat Veterans Group, Inc. (CVG). The CVG is not a VA recognized or sanctioned veterans service organization. The CVG had been given space and other hospital resources until current medical center leadership reviewed space utilization and identified safety concerns, and removed the organization from the premises.

Due to ongoing concerns of staff and patients, medical center management requested a program review by Veterans Integrated Service Network (VISN) 7 clinicians. The VISN consultants found that groups being run for PTSD patients were educational in nature, and not therapy as prescribed. Further, it was found that the groups were walk-in, non-scheduled activities that were often run by the veterans themselves, were cancelled without notice, and admission to the group was determined by the CVG. The consultants found that the PTSD program was decidedly geared toward gaining veterans' compensation benefits, not therapy and treatment.

At the request of the Medical Center Director, a VISN psychologist with expertise in PTSD has been detailed to the facility for the past several months to assist with organization and implementation of the PTC, as well as other mental health programs. The facility is now recruiting for a supervisory psychologist with strong clinical and leadership skills to manage the PTC and other mental health programs. The facility is further revising clinic profiles to more accurately reflect educational vs. therapeutic groups. Until therapeutic clinic groups are held, the medical center will not authorize beneficiary travel payments to PTSD patients who attend educational group sessions.

Because the implementation of the PTSD treatment center has continued to lag, a substantial and highly vocal number of PTSD patients visited us, to express their concerns about the management and future of the PTC. Most patients expressed support for the mental health psychiatrist who had been treating them for years and who was reportedly a member of their group, CVG. While at the same time, they expressed fear and anger toward medical center management regarding the changes that were made that affected the status of the CVG and its inability to regain space on the medical center grounds. They also were concerned about the impact of the VISN consultants' recommendations on their eligibility for beneficiary travel, and the treatment of their conditions. Most often there was a general expression of poor communication with, and a general mistrust of medical center management, reportedly because of a history of unkept promises to implement the PTC.

Conclusion This is a very sensitive and emotionally charged area that needs a great deal of continued medical center management attention and VISN support.

Recommendation 3 The Medical Center Director should continue to work to enhance communications with and overcome a general attitude of distrust by PTSD patients, expedite the staffing and implementation of the PTC, and continue to seek VISN 7 support as needed.

Medical Center Director's Comments

We concur with this recommendation and have implemented the following:

Quarterly meetings with the Triad, Post Traumatic Stress Care Team (PCT) staff and patients have provided a setting for open communication. The first meeting took place December 9, 1999 and will continue.

A clinical Psychologist, with experience in Post Traumatic Stress Syndrome, has been hired to manage the PCT program. She entered on duty February 15, 2000.

Primary Care Management and Customer Service staff will emphasize our open door policy that allows patients to address issues or concerns.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions

Clinical Staffing Needs

As of October 29, 1999, the medical center had identified 43 administrative and clinical positions which it had plans to fill. At the time of our visit, recruitment action had been initiated for many of these positions. Some of the unfilled positions that were of concern to the CAP team were 23.5 patient care providers, including 19 nursing positions (10 of which were over ceiling bachelor degreed registered nurse positions*),* 2 hospitalists, a psychiatrist, a psychologist, and a part-time cardiologist. In addition to those identified needs, there had been a recommendation made in April 1999 by an outside consultant to hire an anesthesiologist due to the volume and complexity of patient workload.

We also noted that staff were not equitably distributed among long-term wards in comparison to each ward's patient workload. There was often an imbalance of staff and workload on certain wards and tours of duty due to light duty assignments and staff absences. It appeared that light duty personnel were concentrated in a few areas creating greater burdens for the remaining care providers. Nursing staff on acute care wards and specialty care areas also complained of staffing and workload imbalances. Over 50 percent (40/79) of the employees who responded to our questionnaire stated that there was not sufficient staff in their area to provide care to all patients who need it.

Recommendation 4 The Medical Center Director should expedite and expand recruitment options and incentives, and monitor and realign nursing resources as necessary, to fill needed positions and correct staffing and workload imbalances in the domiciliary, PTSD program, long-term care, and occupational therapy.

Medical Center Director's Comments

We concur with the recommendations.

We have recently hired 7 nurses and currently have only a 1.7 FTEE Registered Nurse vacancy. We are continuing to recruit for 10 bachelor prepared nurse positions.

The Resource Management Committee has formed a task force to improve communication, and clarify roles such as recruitment, staffing, scheduling, light duty issues, organizational relationship between Service Line Managers, Business Managers, Nursing staff and Chief Nurse Executive, process for change in policy and chain of command for grievances. The committee consists of the Associate Director, Service Line Business Managers, Chief Nurse Executive, a HRM representative and Union officials. The meetings began December 1999 and are ongoing.

Three internist, plus one Psychiatrist and one Psychologist positions have been filled. We are in the Credentialing and Privileging process with two candidates for the Cardiologist position.

Candidates for the Occupational Therapist position have been forwarded to the Geriatrics and Extended Care (G&EC) service line for selection.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions

B. Opportunities to Further Improve Internal Controls and Enhance Employee Morale

We concluded that overall the medical center maintained an effective system of internal controls. As discussed in more detail below, we reviewed and tested controls in 13 areas and found that controls were generally working effectively. Areas which require greater management attention include: reducing excess inventory costs of medical supplies; reducing the lag time for billing third-party insurers; and improving the documentation of means tests. We also concluded that management needed to address employees' concerns about the quality of patient care, work environment, and management personnel practices, in order to enhance employee morale.

Results

Most Controls Were Working Effectively

Agent Cashier Controls – Appropriate Level of Advance

The Agent Cashier cash turnover rate was established in accordance with VA Financial Policy Manual Change 78, MP-4, PT 1, Chapters 1 and 2 and TWX92G4-15, which directs that the entire advance must be turned over 100% every 3 weeks.

We reviewed records of unannounced audits of the agent cashier covering the period from October 1997 to November 1999 and discussed procedures used to conduct these audits with the Business Office Manager. We noted that for the last five unannounced audits, conducted from January 1999 to November 1999, the agent cashier cash advance 3-week turnover percentage rate ranged from a high of 99 percent to a low of 77.5 percent. We concluded that the Business Office Manager should review the level of the agent cashier advance to determine the appropriate level of advance. The Business Office Manager concurred that the cash advance was at times excessive and will be reviewing the advance in January 2000 to determine the cash advance needs of the facility.

Timekeeper Controls

VA policy provides that generally, a unit timekeeper or an alternate timekeeper will not be permitted to maintain his/her own time and attendance report. VA Form 4-5631, Time and Attendance Report, serves as the official time and attendance record for all VA employees. Exceptions may be made in those instances where it has been determined it is an impractical requirement due to such factors as a lack of clerical personnel, leave status of unit timekeepers or alternate timekeepers, etc. Also, each facility is required to conduct annual refresher training for all unit timekeepers. This training provides an opportunity to

disseminate and explain new instructions and procedures relating to time and leave matters to unit timekeepers.

We reviewed controls over timekeepers to ensure the integrity of reported time and leave data and to verify that adequate separation of duties existed over time and attendance. Six timekeepers were maintaining their own timecards; however, a payroll supervisor reviews timecard entries and signs off on each timekeeper's time and attendance report. A review of timekeeper training records showed that unit timekeepers received refresher training during FY 1999.

We concluded that controls over unit timekeepers are in place to ensure the integrity of reported time and leave data. We also concluded that unit timekeeper training was conducted during FY 1999.

Current and Ex-Employee Accounts Receivable

We reviewed 34 receivables due from current and ex-employees valued at $80,515. We found that the medical center correctly established these receivables and notified employees of their right to appeal and defer collection while in the appeal process. Both current and ex-employees can exercise their right to request a waiver of debt through the VA Regional Office Committee on Waivers.

Information Technology Acquisition

Office of Information Resources Management (OIRM) procedures require OIRM approval to procure information technology (IT) resources (hardware, software, and services) that exceed $250,000. In December 1996, OIRM removed the prior approval requirement for acquisitions made using the VA Procurement of Computer Hardware and Software (PCHS) contract.

We reviewed medical center acquisitions of IT services and equipment in FYs 1998 and 1999 for compliance with approval requirements. We found that medical center acquisitions did not exceed the established threshold requiring IRM approval nor did the medical center acquire IT resources from the PCHS contract.

Physical Inventory of Non-expendable Equipment

VA facility staff is required to perform physical inventories of non-expendable equipment and reconcile the inventory counts to accountable records in accordance with VA Handbook 7127.

The value of the 47 equipment inventory listings (EILs) of non-expendable equipment totaled $13.9 million as of September 30, 1999. We found that 7

(15 percent) of 47 equipment inventory listings valued at $2.1 million were not completed in FY 1999 as required.

The supervisor of the inventory management and distribution section indicated that staffing shortages and the time it takes to inventory equipment are the main reasons for not completing inventories on time. The remaining seven inventories were planned to be completed by November 30, 1999.

The completion of each EIL should be more closely monitored to ensure that physical inventories of non-expendable equipment are performed as required.

Purchase Card Transactions Were Generally Reconciled and Approved

VA medical centers are required to use government purchase cards for small purchases of goods and services (usually $2,500 or less). The purchase card program at VAMC Dublin includes 39 purchase cardholders and 15 approving officials. Purchase cardholders processed 5,940 transactions totaling approximately $3.87 million from October 1, 1998 through September 30, 1999.

VHA Handbook 1730.1, 2.g. (6) requires each cardholder to reconcile payment charges within 5 days of data entry into the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system to ensure that the charges billed are accurate. The reconciliation involves maintaining appropriate documentation to support purchases and providing approving officials with applicable documentation to enable certification of the invoices for payment.

We found that during FY 1999, cardholders did not reconcile 312 transactions (5 percent) of the total transactions of 5,940 valued at $127,655 within the required 5-day time frame. The time interval from payment date to reconciliation date ranged from 8 days to 30 days.

VHA Handbook 1730.1, 2.h. (7) requires each approving official to certify reconciled payment charges in IFCAP within 14 days of receipt from the cardholder. The certification ensures purchases are within cardholder's assigned limits, purchases have applicable supporting documentation, and purchases over $2,500 are not split to stay within monetary limits.

Our review of approving official certification for the FY 1999 showed that approving officials did not certify 624 transactions valued at $374,140 within the required 14-day review and certification period. The time interval from reconciliation date to approval date ranged from 19 days to 30 days.

The purchase card coordinator monitors purchase card activity through several standard reports that are run daily and monthly. The areas of focus include unreconciled purchases, timeliness of input into IFCAP, and timeliness of reconciliation by cardholders and certifications by approving officials. Further, in

accordance with the purchase card program standard operating procedures, the coordinator audits purchase card orders on a quarterly basis.

We concluded controls were generally working effectively. The purchase card coordinator should continue monitoring cardholders and approving officials who are delinquent in reconciling and certifying purchase transactions.

Controls Over Beneficiary Travel Reimbursement Could Be Improved

In the month of October 1999, VAMC Dublin paid $17,620 in beneficiary travel expenses to eligible veterans receiving treatment from the hospital. The Disabled American Veterans (DAV) provides a courtesy vehicle to transport veterans who request this service, free of charge, to the medical center. We reviewed the DAV logs, and judgmentally selected 28 persons, to match to the VAMC's Beneficiary Travel Output By Account for the same month. We found six veterans (21 percent) who were transported for free by the DAV, claimed reimbursement and were paid from the VAMC's beneficiary travel office. The amount paid to these six veterans was $94.68. The VAMC has established overpayments for the identified veterans.

We concluded that beneficiary travel personnel should obtain and review DAV logs to ensure veterans transported for free are not reimbursed for travel expenses.

Obligations Were Generally Effectively Reviewed

VA requires that stations conduct a review of open accounts in connection with fiscal year end procedures. Station personnel will review all payables in terms of prospect of payment and undelivered orders (UDOs) to determine if they meet the requirements of an obligation. Accrued Services Payable (ASPs) are funds obligated for various services which frequently represent estimates for services to be performed during specified periods of time. UDOs represent obligations for goods to be delivered by a specified date.

We reviewed 30 obligations valued at $449,994 from Financial Management System Reports for the Accounting Period Ending September 30, 1999 to determine the validity of ASPs and UDOs. Our review consisted of the following samples: (1) a sample of 20 ASPs valued at $156,818, and (2) a sample of 10 UDOs valued at $293,176. The results of our review showed:

- Two (10 percent) of 20 ASPs valued at $17,931 should have been deobligated prior to September 30, 1999.

- One UDO totaling $302 should have been deobligated as part of the year-end closing review.

According to accounting personnel, these obligations were overlooked during the end of year review. Action has been taken to close these obligations based on OIG inquiry.

To improve funds management, accounting personnel should ensure timely completion of reviews of all obligations in connection with fiscal year end procedures.

Strengthening Controls in Some Areas Could Help Reduce Costs, Increase Revenues and Improve Compliance with Means Testing Procedures

Medical Supply Inventories Exceeded Current Operating Needs

Medical supplies are defined as expendable hospital, surgical, laboratory, and radiology items used in patient care and medical research. They include items such as examination gloves, catheters, disposable scalpels and syringes, respirator supplies, sutures, and x-ray film. VA medical centers should ensure that medical supply inventories do not exceed a 30-day level of need. The Under Secretary for Health's Information Letter on Medical Center Inventory Management (IL 10-96-007) dated May 16, 1996, stresses the need for VHA management to place emphasis on inventory management in their operating and business plans. These plans should include the use of modern acquisition and materiel management systems such as prime vendors; bar-coding; automation such as IFCAP/General Inventory Program (GIP); and a coordinated internal materiel management strategy.

We found that inventory controls at VAMC Dublin were adequate. The medical center was not using prime vendors for their medical supplies; however, the network was looking into this issue. GIP bar coding/scanning was used extensively. Supply Processing and Distribution (SPD) had 31 distribution points and managed inventory for surgery, radiology, nuclear medicine and respiratory care. Only the domiciliary, dental, rehabilitation medicine, recreation and the laboratory were not on the system. Dental was in the process of uploading inventory data to the GIP, but the Operations Service Line Manager felt that SPD did not have sufficient staff to service these areas. Our review of the medical supplies inventory found that 32.5 percent of supply items on-hand exceeded the 30-day stock level.

The Acquisition and Materiel Management primary inventory point had 196 medical supply line items valued at $81,620. Based on the Days of Stock on Hand Report, 154 (78.6 percent) of the 196 line items had stock on hand exceeding the 30-day level. The value of the supplies on hand, which exceeded the 30-day level, was $37,630 (46.1 percent of the total value).

The SPD primary inventory point had 582 medical supply line items valued at $144,380. Based on the Days of Stock on Hand Report, 327 (56.2 percent) of

the 582 line items had stock on hand exceeding the 30-day level. The value of the supplies on hand, which exceeded the 30-day level, was $35,842 (24.8 percent of the total value).

Conclusion The medical center should reduce excess inventories of stock on hand.

Recommendation 5 The Medical Center Director should strengthen inventory controls of medical supplies to ensure excess stock is not maintained and inventory costs are minimized.

Medical Center Director's Comments

We concur with the findings that some improvements can be made in the area of inventory control.

To improve overall effectiveness of the Inventory Management Program the Operations Service Line Manager will prepare quarterly status reports for the Associate Director detailing inventory levels and opportunities for improvement. First report is due March 2000.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

Timely Billing Could Enhance Collections

We noted significant lag times occurred between the date care was provided and the billing date. We found that 16 of the 45 billings to insurance carriers (36 percent), valued at $102,803, had billing lag times ranging from 2 months to 10 months. The facility collected a total of $1,586 on 2 of the 16 bills. In the remaining 14 bills, the facility obtained no payment from the insurance carrier. The average number of days elapsed for these bills totaled 166 days. A recent national audit of the MCCF program found that the private sector hospitals took an average of 9 days to issue bills to insurance carriers.

Conclusion MCCF staff should continue to improve billing timeliness to enhance third party collections.

Recommendation 6 The Medical Center Director should review the billing process and initiate action to reduce billing lag times to insurance carriers.

Medical Center Director's Comments

We concur with the recommendation.

One of the most significant issues involved with the lag time in billing is the coding and close out of medical records. In order to expedite this process, we are recruiting additional coders and began use of overtime in February 2000. In addition all five existing coders are in training to become certified coders and will complete the training by April 2000.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

Means Testing Activities Should Be Improved

In accordance with Title 38, United States Code, the Veterans Health Administration (VHA) collects fees (co-payments) for medical care and medications provided to certain veterans for non-service connected (NSC) conditions. VHA also collects from third party health insurers the cost of medical care furnished to insured veterans for treatment of NSC conditions. Each year veterans who receive care for NSC conditions must provide VHA with family income information (means test) and health insurance information. By signing their means test disclosures, veterans attest to the accuracy of the income information and certify receipt of a copy of the Privacy Act Statement. The Privacy Act Statement advises veterans that the income information they provide is subject to verification by computer matching with the income records of the Internal Revenue Service and the Social Security Administration. VHA facilities are required to retain signed means test forms in the veterans' administrative records. In addition, veterans must make co-payments if their families' annual income exceeds statutory levels.

We reviewed 32 sample cases from a universe of 580 cases for the period May 1, 1999 through August 27, 1999, at the VAMC Dublin. Although the medical center staff entered means test information into the veterans' records, we found that in 7 of the 32 cases (22 percent) there was no signed means test on file for the veteran. In most of these cases, the veterans were not actually means tested.

Conclusion Intake procedures need to be improved to ensure means tests are conducted and documented, not only to prevent Privacy Act violations, but also to identify billable episodes of care. The medical center's controls were not sufficient to ensure that means testing was properly conducted.

Recommendation 7 The Medical Center Director should strengthen procedures and controls for means testing activities and conduct periodic reviews to prevent Privacy Act violations and better identify billable episodes of care.

Medical Center Director's Comments

We concur with this recommendation.

A Means Test monitor was implemented in December 1999 to ensure all scheduled appointments requiring a means test are complete and has the veterans' signature. The eligibility staff files the completed test in the Administrative Record to further ensure 100% compliance. Monthly reports are submitted to the Associate Director.

A Standard Operating Procedure (SOP) has been developed that provides guidelines for processing of data collection on means tests. This SOP has been reviewed by Service Line/Business Managers to ensure compliance by staff.

Office of Inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

Opportunities to Enhance Employee Morale

Based on our observations and analyses of employee interviews and questionnaires, we concluded that employee morale was low. A primary factor contributing to this condition appeared to be the continuing efforts of management to restructure and reorganize hospital operations as it moves toward achieving VHA and VISN goals to increase cost efficiency, enhance revenues, and improve the quality of patient care. An environment of continuous change and restructuring was also identified during a previous OIG visit in June 1997. At that time, clinical managers were concerned about the impact of these changes on the morale of employees and they saw a need for management to keep employees better informed of upcoming changes and generally how to deal with a changing environment. During our visit in November 1999, we distributed questionnaires to 142 randomly selected employees, interviewed 30 clinicians/care givers, and were visited by 53 additional employees who wanted to express their concerns and complaints about management practices. Our assessment of the information, perceptions, and complaints made by these employees is that management can enhance employee morale by addressing their concerns about various aspects of the quality of patient care, overall work environment, and personnel management practices.

We found that 24 of the 80 employees who responded to our questionnaire (30 percent) indicated that they would not recommend medical treatment at VAMC Dublin to a friend or relative. We also noted that since our last evaluation in June 1997, caregivers' concern about the quality of patient care has increased. For example, in 1997, 9 of the 30 clinical managers interviewed (30%) told us that they would not recommend medical care at VAMC Dublin to a friend or relative. Additionally, 12 of 34 clinicians (35%) told us that only some of the time or rarely would they recommend medical care at this facility. During this review, 50 percent of the clinical managers and 56 percent of the clinicians surveyed stated they would not recommend care at VAMC Dublin or only recommend it some of the time. We also found that, although patients were generally satisfied with the quality of care and the treatment provided, 50 percent of the clinical managers and over 66 percent of clinicians felt the quality of care and satisfaction with it was fair or poor.

Regarding work environment, 56 of the 80 employees who responded to the questionnaire (70 percent) told us that their workload was unmanageable, 31 (39 percent) felt resources were inadequate to be efficient, and 40 (50 percent) stated there were insufficient staff in their functional area to adequately care for patients.

All of the clinical managers and 86 percent of the clinicians surveyed felt necessary medical technology and specialized care was not available at this facility. In addition, 80 percent of clinicians and 57 percent of clinical managers, felt staff never, or only some of the time, had time to spend with patients when the patients were anxious or in need of emotional support. Other areas of employees' concern and indicators of low morale were that 26 of responding employees (32 percent) did not look forward to going to work and another 14 (18 percent) were neutral. Nineteen (24 percent) felt that the quality of care was not a source of job satisfaction, while another 16 (20 percent) were neutral. Twenty employees (25 percent) did not feel safe coming to and leaving the work place, while 17 (21 percent) did not feel safe from physical harm in the work place. Only 39 (49 percent) of the employees felt strongly that the facility was an employer of choice.

Many employees also expressed dissatisfaction and general lack of trust with management personnel practices. In response to our questionnaire: 50 of 80 employees (63 percent) believed that recognition and awards did not adequately reflect performance; 44 (55 percent) felt that incompetence was encouraged and rewarded; and 53 (66 percent) stated that who you know is what counts, not what you know.

This level of dissatisfaction was further reinforced by many of the 53 employees who requested to speak to us during our visit. The 53 employees who spoke to us presented 126 complaints; 63 (50 percent) of the complaints were about personnel issues, including inadequate staff and unfair distribution of awards.

Another 24 complaints concerned communication issues. Staff felt that management never sought input or responded to concerns. In addition, staff felt that the director was not visible enough.

In response to the number of complaints about the reward system, we reviewed awards that were granted over the past 18 months. Our analysis of award distribution showed the following statistics. The director's office had 39 employees, 14 of whom received 20 awards; the business office had 22 employees, 13 of whom received 16 awards; and the human resources office had 6 employees, 5 of whom received 5 awards. Conversely, operations had 183 employees, but no one received an award; and geriatrics had 182 employees, 15 of whom received 16 awards. This analysis indicates that the reward system needs to be reviewed and more closely monitored to ensure that award criterion is followed and deserving staff from all hospital operations are appropriately recognized and rewarded.

Conclusion Management is continuing to restructure and reorganize hospital operations. These continuing changes have affected the perceptions and raised the level of concern that many employees have regarding the quality of patient care, the work environment, and personnel management practices. As a general observation, medical center management should take a proactive approach in examining its mechanisms for airing and resolving employees' concerns to ensure that they are both effective and trusted. In building that trust, management should also examine and monitor its system of rewards and recognition.

Recommendation 8 The Medical Center Director should develop a plan of action to address employees' concerns and perceptions regarding the quality of care, work environment, and personnel practices. The plan should include review of medical center mechanisms for airing and resolving employee complaints; and examination of the medical center's system for employee rewards and recognition.

Medical Center Director's Comments

We concur with the recommendation.

A new Award Policy was being developed prior to the CAP team visit. A copy of the draft policy was shared with a member of the CAP team. The draft policy will be finalized by March 21, 2000 and a copy will be given to all employees and discussed at staff meetings. Supervisory staff will receive training regarding implementation of this new policy. Human Resources will monitor all awards to ensure participation throughout the medical center. Semi-annual reports will be provided to the Director, Associate Director, and Chief of Staff.

We have established the following action plan:

A. Concerns and perceptions about quality of care

1. We will provide examples of positive letters and phone calls to our staff. “Customer Service Achievements” that would highlight quality of care will be posted in the Canteen. In addition, we will share positive information with the clinical staff through Director’s Staff meetings, Physician Staff meetings, Head Nurse meetings, and public announcements.

2. We will seek feedback from employees by being more visible on evening and night tours. Clinical leaders will visit each unit quarterly during all tours including weekends and holidays. Director and Associate Director will make rounds on a quarterly basis.

3. We will increase employee awareness of the anonymous complaint hot line and Tell it to the Director program through reminders to staff and by advertisements in the medical center newsletter, the Vinson Vine.

4. Chief of Staff meetings with physicians and physician assistants will be held bi-monthly.

B. Work Environment

1. Nurse mangers will meet weekly with the Service Line Business Manager and the Chief Nurse Executive to improve communication on issues that directly impact work environment.

2. Associate Director will continue Environmental Rounds. The Chief of Staff and Chief Nurse Executive will attend when the inspections are in clinical areas.

3. We will remind staff about the advanced technology we have to offer which enhances our work environment. CPRS, Internet Access, Video teleconferencing and other advanced systems will be featured in The Vinson Vine. Each month the Office of Professional Practice will prepare an article relating to improvements in the work environment from these advance technologies.

C. Personnel Practices

1. We will reinforce the need for supervisors to recognize employees for exceptional efforts displayed in their work areas. HRM will provide a semi-annual report to the Director detailing the distribution of awards.

2. We will introduce new employees via e-mail to all staff. This introduction will provide background on these employees and will serve to improve communication on personnel matters and program changes.

3. We will continue to offer communication to the staff via Town Hall meetings and Open Door Sessions with the Director.

Office of inspector General's Comments

The Director's implementation plans are acceptable and we consider this issue resolved. The OIG will follow-up on the implementation of planned corrective actions.

Appendix I

Fraud and Integrity Awareness Briefings

An OIG Resident Agent in Charge conducted four fraud and integrity briefings. Approximately 178 individuals from all services in the medical center attended the briefings, which included a lecture, a short film presentation, and question and answer opportunities. Each session lasted approximately 1 hour and 15 minutes. The material covered in the briefings appears below.

Reporting Requirements

VA employees are encouraged, and in some circumstances required, to report allegations of fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1, Chapter 16 lays out the responsibility of VA employees in reporting such allegations. Subordinate employees are encouraged to report such activities to their management. However, 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 available auditor, investigator, or healthcare inspector. Management is required to pass along these allegations to the OIG once they have been made aware of them. The OIG is heavily dependent upon VA employees to report suspected instances of fraud, waste, and abuse; and for that reason, the contacts are handled confidentially.

Referrals to the Office of Investigations - Administrative Investigations Division

The Administrative Investigations Division investigates allegations of serious misconduct on the part of VA officials that are not criminal in nature. Such an example would be misuse of a government owned vehicle by a senior VA official.

Referrals to the Office of Investigations - Criminal Investigations Division

Upon receiving an allegation of criminal activity, the Office of Investigations will assess the allegation and make a determination as to whether or not an official investigation will be opened and conducted. Not all referrals are accepted. If the Office of Investigations decides to open a case, the matter is assigned to a case agent, who then conducts an investigation. If the investigation substantiates criminal activity, the matter is then referred to the Department of Justice (DOJ), usually through the local US Attorney's Office. DOJ then determines whether or not it will accept the matter for prosecution. Not all cases referred to DOJ by the OIG are accepted.

If DOJ accepts the case, either an indictment or a criminal “information” follows. These two vehicles are used to formally charge an individual with a crime. Following the issuance of an indictment or information, an individual either pleads guilty or goes to trial. If a guilty plea is entered or a person has been found guilty after trial, the final step in the criminal referral process is sentencing. If the investigation only substantiates administrative wrongdoing, the matter is referred to management, usually the medical center or regional office director, for action. Management, with the assistance of Human Resources and Regional Counsel, will determine what administrative action, if any, to take.

Important Information to Provide When Making a Referral

It is very important to provide as much detailed information as possible when making a referral. The more information we know before we formally begin the investigation; the faster we can complete it. There are five items one should always provide, if possible, when making a referral. They are:

1. Who — We need names, position title, connection with VA, and other identifiers.
2. What — Specify the alleged illegal activity.
3. When — Dates and times are critical.
4. Where — Specify the locations where the alleged illegal activity has occurred or is occurring.
5. Witnesses and Documents can substantiate the allegation.

Specifics are vital. Don’t just say, "an employee is stealing from the medical center." Say, "I saw John Doe, engineering technician, take buckets of paint from the VA warehouse and place them in his personally-owned truck on January 2, 1998. John Doe is building an addition to his house. Jane Doe, procurement clerk, recently purchased 100 gallons of paint to finish the clinical addition. The paint was delivered to the VA warehouse on December 29, 1997."

Importance of Timeliness

It is important to report allegations promptly to the OIG. Do not wait years to call. Many investigations rely heavily on witness testimony. The greater the time interval between the occurrence and an interview, the greater the likelihood that people will not recall the event in significant detail. Over time, documentation can be misplaced or destroyed. Also, most Federal criminal statutes have a 5-year period of limitations. This means that if a person is not charged with committing a crime within 5 years after its commission, in most instances the person can not be charged.

Areas of Interest for the Office of Investigations - Criminal Investigations Division

The Office of Investigations, Criminal Investigations Division, is responsible for conducting investigations of suspected criminal activity having some VA nexus. The range and types of investigations conducted by this office are very broad. VA is the second largest Federal department, and it does a large volume of purchasing. Different types of procurement fraud include bid rigging, defective pricing, double or over billing, false claims, and violations of the Sherman Anti-Trust Act. Another area of interest to us is bribery of VA employees, which sometimes ties into procurement activities. Bribery of VA officials can also extend into the benefits area. Other benefits-related frauds include fiduciary fraud, Compensation and Pension fraud, loan origination fraud, and equity skimming. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, improper fee basis billings (medical and transportation), and conflicts of interest. Still more areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by both staff and beneficiaries.

The videotape presentation covered the same basic information but was replete with real life scenarios. Attendees were provided with points of contact for VAOIG and were encouraged to call and discuss any concerns regarding the applicability of bringing a particular matter to the attention of VAOIG.

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

Medical Center Director's Comments

Department of Veterans Affairs

Memorandum

Date: February 18, 2000

From: Medical Center Director (00), Carl Vinson VAMC, Dublin, GA

Subj: Combined Assessment Program Review, Draft Report

To: Director, Bedford Audit Operations Division (52BN)

1. Included in pertinent sections of the subject draft report are the Carl Vinson VA Medical Center's responses to the OIG team's observations and recommendations resulting from your visit, November 15 – 19, 1999. We concur with the findings and recommendations and have provided specific implementation plans to address the issues raised.

2. If you have further questions, please have your staff call Gail Haley, Special Assistant to the Director, at 912-277-2701.

/s/James F. Trusley III

Report Distribution

VA Distribution

Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Financial Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Planning and Analysis (008)
General Counsel (02)
Deputy Assistant Secretary for Finance (047)
Deputy Assistant Secretary for Congressional Operations (60)
Deputy Assistant Secretary for Public Affairs (80)
Chief Network Officer (10N)
Chief Information Officer (19)
Director, Carl Vinson VA Medical Center (557/00)
Veterans Integrated Service Network Director (10N7)

Non-VA Distribution

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
- Chairman, House Committee on Veterans’ Affairs, Subcommittee on Hospitals and Health Care
- Ranking Member, House Committee on Veterans’ Affairs, Subcommittee on Hospitals and Health Care

Senator Max Cleland, Georgia
Senator Paul Coverdell, Georgia