Department of Veterans Affairs

Office of Inspector General

COMBINED ASSESSMENT PROGRAM REVIEW
VA North Texas Health Care System

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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 (OIG'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.

Executive Summary

Combined Assessment Program Review

VA North Texas Health Care System

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs (VA) North Texas Health Care System (System). The purpose of the review was to evaluate selected clinical and administrative operations, focusing on the quality of care and the effectiveness of management controls. We also provided fraud and integrity awareness briefings to System employees.

2. The System is an integrated health care provider comprised of the Dallas VA Medical Center, the Fort Worth Outpatient Clinic, and the Sam Rayburn Memorial Veterans Center in Bonham, Texas. As of February 8, 2000, these facilities had a total of 871 beds -- 131 acute medical, 16 intermediate medical, 79 surgical, 51 psychiatric, 240 nursing home, and 264 domiciliary beds, a 30-bed Spinal Cord Injury Unit, and a 60-bed Psychiatric Residential Rehabilitation Treatment Program. Available services include cardiac surgery, hemodialysis, magnetic resonance imaging, lithotripsy, radiation therapy, adult day health care, and hospital-based home care. In Fiscal Year 1999, the System treated 63,987 unique patients. Medical care expenditures totaled about $259.7 million.

3. The OIG CAP team visited the Dallas and Bonham facilities from February 28 to March 3, 2000. The Introduction to this report provides more detailed information about the System and the purpose, scope, and methodology of the CAP review. The Results and Recommendations section describes 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 need greater management attention:

- Patient Care and Quality Management – While we found that the System 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: waiting times for prescribed medications; delays in obtaining specialty clinic appointments; adequacy of the computer system; adequacy of facilities for the treatment of mental health patients; cleanliness in certain areas; patient privacy in consultation rooms; preparation

of surgical instrument trays; perceptions of the employee recognition and awards program; documentation of treatment goals; documentation of informed consent; and documentation of actions taken in response to recommendations by a Board of Investigation. For more details, see page 3.

- Financial and Administrative Controls – Overall, the System maintained effective financial and administrative controls. For most controls tested, we identified only minor deficiencies. Areas which require greater management attention include: security measures at the Bonham facility; reconciliation and approval of purchase card transactions; medical supply inventories; access to information systems; documentation of means tests; controls over time and attendance reporting; and accrued services payable and undelivered orders. For more details, see page 14.

- Fraud and Integrity Awareness Briefings – These briefings discussed issues concerning the 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 page 25.

4. The System Director concurred with the recommendations and provided acceptable implementation plans. We consider all issues resolved. However, we may follow up on implementation of planned corrective actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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INTRODUCTION

Purpose

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

Scope and Methodology

We reviewed selected clinical activities at the Department of Veterans Affairs (VA) North Texas Health Care System (System) to evaluate the effectiveness of quality management and patient care management. We inspected patient care areas, reviewed pertinent quality management and clinical records, and interviewed managers, staff, and patients. We also used questionnaires to survey employees' and patients' perceptions of the quality and timeliness of care provided.

Our assessment of general financial and administrative controls included reviews of the following areas:

- Approval of information technology procurements
- Handling of denied insurance claims
- Contract ambulance usage
- Controls over fee basis payments
- Equipment accountability
- Audits of agent cashier activities
- Cancellation of debts owed by former employees
- Security measures at the Sam Rayburn Memorial Veterans Center
- Reconciliation and approval of purchase card transactions
- Medical supply inventories
- Access to information systems
- Documentation of means tests
- Controls over time and attendance reporting
- Accrued services payable and undelivered orders

To assess controls, we analyzed operational reports and statistics and interviewed appropriate managers and staff. In addition, we tested selected transactions for the period from October 1998 through February 2000.

In an effort to enhance System employees' awareness of fraud and understanding of the Office of Inspector General's (OIG's) role in investigating indications of fraud, we presented four fraud and integrity awareness briefings. These briefings were attended by 43 employees.

Background – System Operations

The System is an integrated health care provider comprised of the Dallas VA Medical Center (VAMC), the Fort Worth Outpatient Clinic, and the Sam Rayburn Memorial Veterans Center (SRMVC) in Bonham, Texas. One of three health care systems included in Veterans Integrated Service Network (VISN) 17, the System provides a continuum of health care services to veterans residing in 38 counties in Texas and 2 counties in Oklahoma. The veteran population in the service area is approximately 500,000.

As of February 8, 2000, the System had a total of 871 beds -- 131 acute medical, 16 intermediate medical, 79 surgical, 51 psychiatric, 240 nursing home, and 264 domiciliary beds, a 30-bed Spinal Cord Injury Unit, and a 60-bed Psychiatric Residential Rehabilitation Treatment Program. Available services include cardiac surgery, hemodialysis, magnetic resonance imaging, lithotripsy, radiation therapy, adult day health care, and hospital-based home care.

The Dallas VAMC is affiliated with the University of Texas Southwestern Medical Center and Baylor College of Dentistry and supports 147 medical resident positions. Each year, approximately 1,300 students from 100 affiliated institutional programs receive part of their training at the facility.

The SRMVC is affiliated with Grayson County College and other allied affiliates offering programs in nursing, social work, dentistry, and psychology.

In Fiscal Year (FY) 1999, medical care expenditures for the System totaled about $259.7 million, and the FY 2000 budget is $284.3 million. FY 1999 staffing totaled 3,118 full-time equivalent employees (FTEE), including 163.6 physician FTEE and 775.8 nursing FTEE. The System's medical research program had 209 active projects and a budget of $3.2 million.

The System treated 63,987 unique patients in FY 1999. This was a 9-percent increase from FY 1998 and a 24-percent increase from FY 1997. Inpatient care was provided to 11,473 unique patients, with an average daily census of 256 in hospital beds, 220 nursing home patients, 235 domiciliary residents, and 41 participants in the Psychiatric Residential Rehabilitation Treatment Program. In addition, the System had a total of 536,543 outpatient visits.

Analyses prepared by System officials indicate medical care costs per unique patient declined 7.9 percent from FY 1997 to FY 1999. During the same period, FTEE per 1,000 unique patients declined 10.6 percent. Both the medical care costs per unique patient and FTEE per 1,000 unique patients were below the national averages for Veterans Health Administration (VHA) facilities.

RESULTS AND RECOMMENDATIONS

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

We concluded that the System's patient care and quality management programs were comprehensive and well managed and that clinical activities were operating satisfactorily, as illustrated by the following examples:

Top Management Showed a Commitment to Quality Management

The System's top management team demonstrated a strong commitment to quality management and performance improvement. Top management supported continuing education for staff in such areas as performance improvement, quality management, and supervisory skills. Many of the employees and patients interviewed made positive comments about the top management team's advocacy of quality improvement and personal efforts in support of patients and employees.

The Quality Management Program Was Comprehensive and Well Organized

Quality Management Service provided direction, coordination, and oversight of the System's quality management program. This comprehensive program included such activities as credentialing and privileging, infection control, occupational safety and health, total quality management, risk management, and patient representative services. Our review showed that quality management staff effectively tracked results of, and ensured appropriate follow-up on, patient incident reports and root-cause analyses. The following were some of the noteworthy accomplishments of management and staff:

- We reviewed 43 medical records of patients who had 1-day or 2-3 day lengths of stay. Based on the available documentation, we concluded that all cases met the admissions criteria and were appropriate.

- In January 1999, the College of American Pathologists granted the Dallas VAMC's Pathology and Laboratory Medicine Service accreditation for 2 years with no recommendations for improvement. In July 1999, the laboratory at the Fort Worth Outpatient Clinic was accredited by the Joint Commission on Accreditation of Healthcare Organizations with a 100 percent score.

- In May 1999, Radiology Service began using a new state-of-the-art computerized radiology system known as the picture archiving and communication system. Waiting time for routine x-rays was 25 minutes.

- Pharmacy Service reduced outpatient medication dispensing errors from 2.61 per 100,000 in the first quarter of FY 1999 to 0.46 per 100,000 in the first quarter of FY 2000.

- The Spinal Cord Injury Unit provided effective education for veterans, their families, and all professional disciplines involved in care and rehabilitation of spinal cord injury patients.

- The System had an active education program for employees and patients, including annual employee needs assessments, satellite programming, and patient health fairs. In addition, college courses were offered at both the Dallas VAMC and the SRMVC.

- The nursing home care and domiciliary units in Bonham were clean and attractive. Patients, family members, clinicians, and management consistently communicated their satisfaction with the care provided and overall operation of the facility.

Most Patients and Employees Were Satisfied with Quality of Care

We interviewed 132 System employees and 110 patients. We also sent survey questionnaires to 625 randomly selected employees, with 269 (43 percent) providing responses. The results of our survey and interviews showed that patients and employees were generally satisfied with the quality of care provided by System facilities. For example, 97 percent of patients and 94 percent of clinicians and managers responding to the questionnaire viewed the quality of care as good, very good, or excellent. Similarly, 97 percent of patients and 98 percent of clinicians and managers rated overall patient satisfaction as good, very good, or excellent.

Delivery and Quality of Certain Patient Care Services Could Be Improved

Waiting Times for Outpatient and Inpatient Prescriptions Should Be Shortened

Employees and patients reported excessive waiting times for inpatient and outpatient medications. About 31 percent of patients and 45 percent of clinicians and managers responding to our survey questions indicated that prescribed medications were rarely or never received within 60 minutes. Employees of inpatient units stated that they experience frequent delays receiving medications requiring immediate administration to patients and that obtaining prescriptions for patients being discharged can take as long as 11 hours.

The Chief of Pharmacy Service was well aware of the high level of patient and staff dissatisfaction with waiting times for medications. The Chief attributed the delays to a shortage of personnel. At the time of our visit, Pharmacy Service had six staff vacancies. To reduce waiting times, Pharmacy Service changed shifts to provide a greater number of staff during the busier afternoon times,

encouraged patients to use the mail-out pharmacy services, and assigned a pharmacist to coordinate the discharge process and check for accuracy and completeness of discharge medications. Implementation of these measures has resulted in a decrease in average waiting times for outpatient prescriptions from 4 hours to 1.25 hours. However, waiting times remain above VHA's standard of 30 minutes.

Conclusion Although corrective actions have been implemented which have reduced delays in obtaining medications, more improvements are needed.

Recommendation 1 The System Director should recruit and fill employee vacancies in Pharmacy Service.

System Director's Comments

Concur.

Pharmacy Service has recently re-organized and increased staffing by changing the employee mix. This resulted in an increase of five pharmacy technicians. In addition, recruitment bonuses and special pay incentives have been approved to recruit pharmacists. Implementation of new processes has also been enacted and has resulted in the following outcomes:

- Discharge medications, as tracked through the Computerized Personal Reporting System (CPRS) software, are being processed in less than 2 hours.

- Waiting times for total outpatient prescription processing is less than 60 minutes (i.e. from time of prescription turn-in until available for pick-up) and is currently meeting the VA standard of 30 minutes fill time.

- Plan to upgrade TeleRx to be more user friendly for patients calling in prescription refills.

- Waiting times are monitored daily by Pharmacy Service and reported to top management the following day.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Delays in Obtaining Specialty Clinic Appointments Should Be Reduced

Patients, clinicians, and managers stated that waiting times for specialty clinics such as Neurology, Orthopedics, and Dermatology were excessive. The VHA standard for initial clinic appointments is 45 days. As of January 7, 2000, a graph of the third available appointment for new patients in Neurology and Orthopedics

Evaluation Clinics showed that waiting times were 193 days and 228 days, respectively. A computer printout for all clinics showed that, as of January 3, 2000, the waiting time for one Dermatology Clinic was 161 days and the waiting time for another Dermatology Clinic was 134 days. Although managers assured us that patients requiring immediate attention could be seen sooner by overbooking, delays in obtaining appointments could affect quality of care.

Conclusion We concluded that management should review specialty clinic appointment availability to identify opportunities for reducing delays in obtaining appointments.

Recommendation 2 The System Director should develop and implement a plan to reduce delays in obtaining specialty clinic appointments.

System Director's Comments

Concur.

VA North Texas Health Care System (VANTHCS) is an active participant with the Institute for Healthcare Improvement (IHI), which is addressing the national initiative of reducing delays and waiting times throughout the VA Health Care System. In addition, VANTHCS has taken the following action to reduce waiting times:

- Hired a Neurologist to work in Ambulatory Care to provide same day access to patients.

- Created an additional Physician Assistant clinic to accommodate post-operative patients for wound checks and minor procedures, as well as any post emergency room visits.

- Evaluating the patient population within the clinics to decrease the mix of patients and assist with patient flow.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

The Computer System Should Be Improved

Managers in Pathology and Laboratory Service, Pharmacy Service, and Ambulatory Care advised us that problems with the computer system adversely affected their daily operations. Clinicians in inpatient and outpatient areas reported that the computer system is slow and impedes efficiency. They also reported that there are insufficient personal computers in inpatient areas to prepare timely documentation. We visited an inpatient unit and three outpatient clinics in order to test the speed of the system and confirmed that delays

occurred. For example, we left the Eye Clinic after waiting 6 minutes to access a patient's record. Additionally, the Chief of Anesthesiology indicated that the software currently in use does not have the capability to capture their ambulatory surgery workload. Other sections, such as Infection Control, reported that the current system is insufficient for their data analysis and trending needs.

Conclusion The current computer system is insufficient to meet the data processing demands placed on it by System users.

Recommendation 3 The System Director should develop and implement a plan to improve computer support of clinical activities.

System Director's Comments

Concur.

This is a national issue in which VANTHCS has been working with Headquarters and VISN 17 to resolve. Two actions have resulted from this process:

- Interim Solution: Procurement of new hardware which is scheduled for installation June 2000.

- Permanent Solution: Procurement of a totally new computer system in which VANTHCS has been approved to be an Alpha Test Site.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Facilities for the Treatment of Mental Health Patients Should Be Improved

The System's acute mental health care and homeless domiciliary units are located in one of the older buildings on the Dallas VAMC campus. Clinicians stated that the rooms for the patients are cramped, run-down, and marginal for their treatment needs, and housekeeping staff stated that the space is difficult to keep clean. Our observations confirmed the employees' statements. In addition, we noted the following specific deficiencies:

- There is only one way to enter or exit the 8-bed locked geropsychiatric unit. In the event of fire in the nursing station or the main hallway, there would not be an alternate route to safely evacuate the patients and employees.

- The geropsychiatric unit has one common bathroom and one shower. The cramped bathroom has no ventilation, and the room had a foul odor at the time of our inspection.

- A 14-bed acute care section also has one common bathroom with only one shower stall.

- The geropsychiatric unit does not have any accommodations suitable for female patients.

System managers were aware of deficiencies of the patient care units and proposed a $26.8 million construction project to alleviate the deficiencies. The proposed Mental Health Enhancement project is the System's and VISN 17's highest priority for major construction funding and ranks among VA's highest priority major construction projects.

Conclusion The space for the inpatient mental health care and homeless domiciliary units is inadequate.

Recommendation 4 The System Director should continue efforts to remedy the deficiencies of space occupied by the acute mental health care and homeless domiciliary units.

System Director's Comments

Concur.

VANTHCS has requested funding for a mental health replacement building to replace the Circa, 1938 building now in use. The project, "Mental Health Enhancement Project (549/115)," is VISN 17's number one construction priority and costs approximately $26.8 million. This project is included in our needs relative to care of female veterans. Specific action will be taken to improve ventilation.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Cleanliness in Certain Areas Should Be Improved

During the CAP review, we inspected various areas, such as public/patient bathrooms; areas around planters, ledges and baseboards; and sinks in several treatment and utility rooms. We noted these areas and waste bins appeared to be not properly cleaned. We also found that rooms where minor surgical procedures are performed were not consistently cleaned in a timely manner. System personnel reported that Environmental Management Service (EMS), which is responsible for housekeeping, had 14 vacancies at the time of our visit.

Conclusion Insufficient staffing in EMS resulted in unsatisfactory sanitation in certain areas.

Recommendation 5 The System Director should recruit and fill employee vacancies in EMS and ensure that proper attention is given to cleanliness in all areas of the facility.

System Director's Comments

Concur.

Environmental Management Service (EMS) has been successful in filling 15 vacancies as of May 1, 2000. This action will enhance the responsiveness of EMS employees to maintain the established schedule on a current basis.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Patient Privacy in Two Consultation Rooms Could Be Enhanced

Two small consultation and examination rooms in the outpatient clinic of the SRMVC did not provide sufficient patient privacy. One room, which contained two desks, was used to assess patients before they were seen by physicians. The other room, which had three desks, was used for patient teaching. Neither room had dividers, and anyone in the rooms could hear others' conversations.

Conclusion The two consultation rooms did not meet patients' privacy needs.

Recommendation 6 The System Director should assess alternatives for providing more privacy in the consultation and examination rooms of the SRMVC's outpatient clinic.

System Director's Comments

Concur.

The Ambulatory Care Renovation Project (#B549-208) has been submitted for approval and funding, which will address this issue. For an interim measure, management will take the necessary action to correct the patient privacy issue in the outpatient clinic.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Surgical Trays in the Operating Room Lacked Appropriate Instruments

Operating Room (OR) employees reported having frequently found incorrect or missing instruments in surgical trays prepared by Supply Processing and

Distribution (SPD) employees. This affects their efficiency when preparing for surgical procedures and contributes to waste as additional trays must be opened to find the correct instruments. The Chief of SPD attributed these errors to the need for additional staffing as well as the need for training SPD employees in the preparation of OR instrument sets.

Conclusion Insufficient staffing and lack of training of SPD employees have affected the efficient operation of the OR.

Recommendation 7 The System Director should recruit and fill vacancies in SPD and ensure that employees preparing surgical trays receive proper training.

System Director's Comments

Concur.

Six positions have been approved to support the Operating Room and Acquisition and Materiel Management (A&MM) is actively recruiting these positions. To expedite the process, Human Resources has been designated as a Delegated Examining Unit for Supply Processing Distribution (SPD) technicians. In addition, VANTHCS is developing an upward mobility track to identify lower graded employees that can perform some specific functions and relieve our more experienced technicians to provide services to the Operating Room.

In the interim, two positions have been moved from other areas in A&MM to bolster the understaffed SPD area. When all of the positions are filled, we will re-evaluate our needs and if necessary, recruit additional staff.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Management Has the Opportunity to Improve Employee Relations

Survey responses indicated System employees were generally satisfied with their jobs. For example, over 80 percent of the employees responding to our questionnaire reported that they gained personal satisfaction from their jobs, 69 percent indicated that they looked forward to going to work, and 56 percent reported that the System was an employer of choice in the community. However, based on our survey results, there was a perception among employees that the employee recognition and awards process was unfair. Forty percent of responding employees reported that awards did not adequately reflect their performance, 49 percent reported that incompetence was encouraged and rewarded, and 49 percent perceived there was favoritism in performance awards.

Conclusion We concluded that System management needed to address the employee perception that the awards and recognition program was unfair.

Recommendation 8 The System Director should evaluate the System's awards and recognition program to determine how best to address employees' perception of unfairness.

System Director's Comments

Concur.

With the implementation of the Pass/Fail annual performance process, individual employee recognition is no longer tied to his/her actual overall job performance. For the past 2 years, VANTHCS has utilized the recognition process by the following methods:

- Group Recognition.

- Individual employee recognition is supported, i.e. special contribution awards; suggestion awards; and special advancement for achievement.

We are in the process of developing new guidelines for our Special Organizational Awards Program. An employee training program explaining the Special Organizational Awards Program procedures will be offered to all employees. In addition, a memorandum from the System Director will be distributed to all employees outlining the procedures. The topic will also be discussed during regularly scheduled all employee meetings in accordance with the provisions of VA Handbook 5451, Part C, paragraph 4.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Treatment Goals for Long Term Care Patients Should Be Documented

We reviewed the medical records of 10 long term care patients for documentation of patient management, interdisciplinary treatment plans, and discharge planning. We found that treatments and medications were appropriate and consultation recommendations, where applicable, were followed. Documentation in all records reflected interdisciplinary treatment team meetings on a quarterly basis. However, 2 of the 10 records lacked updated patient goals, and 4 records did not include evidence that the patients were meeting the goals established by their treatment teams.

Conclusion Documentation of treatment goals for long term care patients and progress in meeting those goals should be improved.

Recommendation 9 The System Director should ensure that treatment goals for long term care patients and progress in meeting those goals are documented.

System Director's Comments

Concur.

VANTHCS has implemented the computerized version of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) for all patients in long term care. This software contains a care planning package which we will utilize, in lieu of our current Care Plan form. We will complete implementation and training in the new care planning package within the next 60 days. This will allow updates to be entered directly in the care plan package in addition to our current use of progress notes and monthly updates.

Office of Inspector General's Comments

The implementation plan is acceptable and we consider the issue resolved.

Informed Consent Should Be Fully Documented

VA patients may accept or refuse any treatment offered to them. In accordance with VHA Handbook 1004.1, *Informed Consent*, certain diagnostic and therapeutic treatments or procedures must be undertaken only with prior, informed consent of the patient. In order to give informed consent, the patient, or the patient's surrogate decision-maker, must understand the nature of the treatment or procedure, the benefits and risks, the alternatives to the proposed course of action, and the expected outcome if the treatment is declined. The practitioner must explain this information in language the patient can understand. The patient must be allowed to ask questions and to make a decision freely without coercion or duress.

Informed consent must be documented in the patient's medical record. The required documentation of informed consent has two components:

- The practitioner must obtain the patient's signature on a VA-authorized consent form or comparable form approved by the VISN or facility.

- The practitioner must document the informed consent discussion between the practitioner and patient in a progress note. The progress note should include 10 specific items, including the patient's mental status, a brief description of the proposed treatment or procedure, a statement that relevant aspects of the treatment were discussed in language the patient understood, and a statement that the patient had the opportunity to ask questions.

We reviewed the medical records of 13 patients who had surgical procedures in December 1999 and found that all of the patients had signed VA-authorized consent forms before the procedures were performed. However, the progress notes did not contain all of the specific elements required to fully document the informed consent discussions between the practitioners and their patients. For example, none of the progress notes specifically described the patient's mental

status at the time of the informed consent discussion. Also, none of the progress notes specifically stated that the patient had the opportunity to ask questions at the time informed consent was given.

Conclusion To protect the interests of patients and practitioners, documentation of informed consent should be improved. The System should develop a checklist to be completed at the time of the informed consent discussion or develop an alternative method to ensure that the discussion includes all of the required elements and is fully documented.

Recommendation 10 The System Director should develop and implement procedures to ensure that informed consent discussions are fully documented in patients' medical records.

System Director's Comments

Concur.

To improve our documentation, we are developing a template for hard copy or electronic application utilizing the information on VA Form 10-0114-T (Informed Consent) which includes the goals. This application will be presented to the Medical Record Committee for review and the Patient Care Committee for approval action.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Corrective Actions for Recommendations by a Board of Investigation Should Have Been Better Documented

We reviewed four Boards of Investigation (BOIs), four Focus Reviews, and two Sentinel Events and found that they were conducted appropriately and in a timely manner. However, in one instance, BOI recommendations were not implemented and reasons for not implementing the recommendations were not documented. Since we identified only one discrepancy, we concluded no formal recommendation was warranted.

Financial and Administrative Controls

Financial and Administrative Controls Were Generally Effective

We concluded that overall the System maintained effective financial and administrative controls. As illustrated by the following examples, we found no significant deficiencies in several areas reviewed.

Information Technology Procurements Were Properly Approved

Office of Information Resources Management (OIRM) policy requires VA facilities to obtain prior approval when acquiring information technology (IT) resources costing more than $250,000. In December 1996, OIRM removed the pre-approval requirement when these purchases are made using the VA Procurement of Computer Hardware and Software (PCHS) contract.

We reviewed acquisitions of IT equipment and services from October 1998 through February 2000 to ensure compliance with approval requirements. We found two acquisitions exceeding the $250,000 threshold. Prior approval from OIRM was obtained for one of the purchases and the PCHS contract was used for the other. Thus, the System was in compliance with current IT procurement approval requirements.

Cost Recoveries Were Increased by Appealing Denied Insurance Claims

Title 38, United States Code, Section 1729, authorizes VA to bill insurance companies or other third parties for the reasonable cost of medical care furnished to veterans for the treatment of non-service-connected conditions. VA Manual MP-4, Part VIII, Chapter 19, requires VHA personnel to request reconsideration when an insurer or other third party denies a valid claim.

To enhance cost recoveries at the System, a utilization review nurse was assigned to review denied claims. Information provided by System staff show the nurse's efforts have been successful. As of February 2000, the nurse had appealed 72 denied claims totaling $664,770. The insurers or other third parties reversed or partially reversed their denials of 44 claims and paid an additional $333,885.

Contract Ambulance Usage Was Well Managed

In an effort to control costs and ensure that all ambulance transportation is clinically indicated, System management assigned a registered nurse to the travel unit in late FY 1998. Requests for ambulance transportation are reviewed by the nurse, who determines whether the requests are properly initiated and decides what mode of transportation is needed.

Our evaluation indicated the procedures for controlling ambulance usage were effective. We reviewed 5 billings representing a total of 57 separate ambulance trips made from July 1999 to February 2000. We found that all of the trips were properly authorized and medically indicated. In addition, we identified no inappropriate charges by the contractor.

Controls Over Fee Basis Payments Were Adequate

Title 38, United States Code, Section 1703(a), authorizes VA to contract with non-VA health care providers to provide hospitalization and other medical care when VA facilities cannot economically furnish the care. In FY 1999, the System spent approximately $3.3 million for fee basis care.

To determine if controls over fee basis payments were effective, we reviewed the records of 21 beneficiaries who received fee basis care in FY 1999. For each beneficiary in our judgment sample, we verified eligibility for treatment, the appropriateness of the amount paid, and whether the cost of care was billable to a private insurance company. We identified no deficiencies.

Equipment Inventories Were Completed

VA Handbook 7127, *Materiel Management Procedures*, requires VA facilities to perform periodic physical inventories of non-expendable equipment and reconcile any discrepancies between the inventory records and the physical counts. As of September 30, 1999, the recorded acquisition cost of the System's non-expendable equipment totaled $101.4 million.

System inventory records for FY 1999 showed the required physical inventories of equipment were completed and discrepancies were investigated. However, one discrepancy involving five notebook computers and a desktop computer was not resolved in a timely manner. When we followed up, the desktop computer was readily located, and, as of March 21, 2000, all but one of the notebook computers had been accounted for. The acquisition cost of the missing computer was $5,610.

Audits of Agent Cashier Activities Were Timely and Identified No Discrepancies

VA Handbook 4010, *Agent Cashier Procedures*, requires an unannounced audit of each agent cashier's advance and undeposited collections at least every 90 days. The criteria provide specific guidance for the conduct and documentation of these audits.

We reviewed the records of unannounced audits of agent cashier activities at the Dallas VAMC and the SRMVC from October 1998 through February 2000. The records showed that unannounced audits were conducted at appropriate intervals and no discrepancies were identified.

We noted only one minor deficiency in audit procedures. The two most recent audits at the SRMVC did not include verification of the continuity of receipt

numbers between those received by the accounting activity and unused receipts in the agent cashier's possession. This required element of the audits was not completed because the receipts had been sent to VAMC Dallas before the unannounced audits at SRMVC in Bonham. Facility management stated this issue would be resolved before future audits are conducted.

Debts Owed by Former System Employees Were Appropriately Canceled

VA Manual MP-4, Part VIII, Chapter 8, states that non-benefit debts owed VA by current or former Federal employees may be collected by offset from current salary, final salary, lump sum payment, or retirement benefits. In addition, when certain conditions are met, debts owed by former employees may be referred to the Internal Revenue Service for offset from tax refunds.

We identified 14 debts owed by former System employees which had been canceled or written off between October 1, 1998, and December 31, 1999. These debts totaled $17,369. We reviewed pertinent records and found that 13 debts totaling $17,329 were appropriately canceled. The remaining debt of $40 should not have been canceled, but we concluded that reestablishing and trying to collect this small debt would not be cost effective.

Controls in Some Areas Needed to Be Strengthened

Two Recent Incidents Warrant Additional Security Measures

We noted two recent incidents at the SRMVC in Bonham which we believe warrant additional security measures.

- On February 1, 2000, the Operations Director at the SRMVC reported a possible bomb threat to VA police. According to the VA Uniform Offense Report, dated February 2, 2000, a patient stated, "If my check gets messed up…, that's all I've got for my kids to go to college on, this place will make Oklahoma City look good." The patient was upset because a physician refused to renew a prescription for pain medication. The VA police report stated that the patient had made similar threats before. As a precaution, VA police reported the incident to the local office of the Federal Bureau of Investigation (FBI). At the time of our review, the patient was regularly treated at the SRMVC and had complete, unrestricted access to the facility.

- In another incident, the wife of a patient threatened a VA physician. The physician stated that he had reason to believe pain medication prescribed for the patient was being diverted to the patient's wife. Consequently, the physician refused to renew the patient's prescription. According to the VA Uniform Offense Report, dated February 14, 2000, the patient's wife, a non-veteran, confronted the physician on February 11, 2000, in the dock area outside the main building. She cursed the physician for not renewing the prescription and stated, "I'm going to get you." The patient's mother told the VA physician that her daughter-in-law had killed a physician in another city

under similar circumstances. According to the patient's mother, the physician refused to write a prescription for the patient's wife and she killed him.

VA police contacted the police in the city where the previous killing allegedly occurred and were informed that the patient's wife has a lengthy, violent criminal history. Her criminal record includes arrests for aggravated assault and reckless conduct with a firearm. In 1993 she was arrested for the murder of a physician. According to the local police, the death of the physician involved a dispute over medications. The murder charge against the patient's wife was reduced to manslaughter, and she was eventually acquitted on appeal. The local police indicated she was acquitted because the physician's own misconduct was partially responsible for his death.

Conclusion We believe the two threats against personnel and property at the SRMVC are credible and additional measures are warranted to reduce the risk of injury to individuals or damage to property.

Recommendation 11 The System Director should take additional measures to assure the safety of staff members and patients at the SRMVC. In our opinion, these measures should include the following:

- Require the patient who made the bomb threat to report to the VA police whenever he visits the facility, and have the police monitor his movements as long as he is on VA property.

- Report the threat against the physician to the FBI.

- Require the patient's wife who threatened the VA physician to report to the VA police whenever she visits the facility, and have the police monitor her movements as long as she is on VA property.

System Director's Comments

Concur.

In specifically addressing the issues presented, the following actions were taken:

- Proper notifications to the appropriate agencies were given.

- Medical Administration Service (MAS) personnel have already been notified to contact Police and Security Service, if either of these individuals come out to SRMVC.

- Our officers will escort these individuals, while on station, as appropriate.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Purchase Card Transactions Should Be Promptly Reconciled and Approved

VA medical facilities are required to use government purchase cards for small purchases of goods and services (usually $2,500 or less). The purchase card program at the System includes 172 purchase cardholders and 84 approving officials. From October 1, 1998, to December 31, 1999, purchase cardholders processed 37,219 transactions totaling approximately $26.7 million.

VHA Handbook 1730.1, paragraph 2, 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 cardholder must match the estimated amount of the purchase with the amount billed, reconcile differences, ensure receipt of the goods ordered, and provide the approving official with applicable receipt records. The approving official must then certify the reconciled payment charges in IFCAP within 14 days of receipt from the cardholder. The certification ensures purchases are within the cardholder's assigned limits, purchases have applicable supporting documentation, and purchases over $2,500 are not split to stay within monetary limits. VA loses the ability to recover erroneous or inappropriate charges from the credit card company if the charges are not disputed within 60 days.

Our analysis of purchase card transactions processed from October 1, 1998, to December 31, 1999, showed that charges were not reconciled or certified in a timely manner. Cardholders did not reconcile 38.3 percent of the transactions within the required 5-day time frame. These transactions totaled $11.8 million. Approving officials did not certify 5.9 percent of the transactions, which totaled $1.5 million, within the required 14-day review and certification period. An additional 8.7 percent of the transactions, which totaled $3.1 million, had not been certified as of February 22, 2000.

Conclusion Purchase cardholders should reconcile charges and resolve discrepancies promptly to ensure that VA does not pay for goods or services that were not received. Approving officials should review and certify transactions in a timely manner to ensure that purchase cards are used appropriately.

Recommendation 12 The System Director should monitor timeliness of purchase card reconciliations and certifications and follow up with frequently delinquent cardholders and approving officials.

System Director's Comments

Concur.

Current procedure is in place to encourage service chiefs to discuss delinquent reconciliations with appropriate staff to encourage compliance with reconciliation requirements. Telephone calls are made and/or memos are sent monthly concerning delinquent reconciliations. Additional efforts will be made to help ensure that approving officials will complete reconciliations in a timely manner.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Medical Supply Inventories Should Be Reduced

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, and sutures.

Medical supply inventories should not exceed current operating needs. The Under Secretary for Health's Information Letter on Medical Center Inventory Management (IL 10-96-007) dated May 16, 1996, states that VHA managers need to emphasize 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, and the IFCAP/Generic Inventory Package (GIP). A recent OIG audit report concluded, and VHA concurred, that medical supply inventories should not exceed a 30-day level (Report No. 9R8-E04-052 dated March 9, 1999).

Acquisition and Materiel Management Service (A&MMS) uses the GIP to manage inventory in the warehouse and SPD activities at the Dallas VAMC and the SPD activity in Bonham. Our review indicated GIP inventory data for the Dallas warehouse and the Bonham SPD were generally accurate, but we found that reported inventory levels for the SPD activity in Dallas were unreliable. The Chief, A&MMS, stated that the Dallas SPD staff had problems implementing GIP and they were in the process of correcting the deficiencies.

GIP data indicated medical supply inventory levels in the Dallas warehouse and the SPD activity in Bonham were higher than needed. Stock levels of 85 percent of the warehouse inventory items and 92 percent of the inventory items in the Bonham SPD activity exceeded the 30-day level. The total value of supplies on hand in excess of the 30-day level was about $497,000. We did not estimate the value of excess supplies in the Dallas SPD activity because the GIP data were unreliable.

Conclusion The System should strengthen inventory controls of medical supplies to ensure excess stock is not maintained. This would reduce the amount of money tied up in inventories and reduce the risk that items will be lost or become outdated.

Recommendation 13 The System Director should reduce the quantities of medical supplies on hand in the Dallas warehouse and the SPD activity in Bonham. Also, correct GIP data for the SPD activity in Dallas and, as soon as the GIP data are considered reliable, reassess stock levels in that activity.

System Director's Comments

Concur.

In March 2000, a complete inventory was conducted in the Dallas SPD. The on hand value prior to the inventory was approximately $950,000. After the inventory and adjustments, the on hand stock levels were reduced to an on hand value of approximately $350,000. A continuous review of the Dallas and Bonham inventories will take place regarding accuracy and appropriate stock levels on hand. New procedures, policies and training are being implemented to ensure that supplies are charged out of SPD properly.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Controls Over Access to Information Systems Should Be Enhanced

VHA Manual M-11, Chapter 16, states that use of VHA information assets (hardware, software, and data) must be restricted to persons with a need for them in the performance of their duties. Also, procedures must be in place to ensure that Information Resources Management Service is informed of changes in employees' status.

We identified six System employees who had access to more functions of the automated information systems than they needed to do their jobs. Five of these employees had the ability to establish, audit, and cancel accounts receivable. Another System employee had the ability to purchase and receive inventory items. These functions need to be separated to allow proper management control.

Access of former employees to information systems was not promptly terminated. A review of the records of 15 former employees who left their jobs at the System between January 1 and February 11, 2000, showed 6 still had access to the information systems as of February 29, 2000. Access had not been terminated because Information Resources Management Service had not been notified of the termination of their employment.

Conclusion We found no evidence that current or former employees had abused their access to automated information systems. However, management should strengthen controls over access to the information systems to reduce the risk of abuse.

Recommendation 14 The System Director should periodically review access to automated information systems to ensure proper separation of duties and provide employees access to only those functions needed to do their jobs. Also, revise separation procedures to ensure that separating employees' access to information systems is promptly terminated.

System Director's Comments

Concur.

The policies concerning computer access have been revised and procedures have been established to perform periodic reviews on employee access. The facility Information Security Officer will be responsible for coordinating the reviews with the various Services and will maintain the documentation on these reviews. New procedures have been established to terminate separating employees' access to the computer system.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Means Testing Activities Should Be Improved

In accordance with Title 38, United States Code, VHA collects fees (co-payments) for medical care and medications provided to certain veterans for non-service-connected (NSC) conditions. Each year veterans who receive care for NSC conditions must provide VHA with family income information (means test). 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 folders.

To assess means testing by System personnel, we reviewed the administrative folders of 48 veterans. These veterans were judgmentally selected from 1,739 veterans whose means test results were input from October 1, 1999, through January 25, 2000, and who were exempted from co-payments. Although System staff input means test information into the veterans' automated records, signed means test disclosures for 11 of the 48 veterans could not be located. In addition, documentation in six veterans' records showed the veterans had chosen not to provide any income information and had agreed to make co-

payments for any treatment they received. One of these veterans had visited the Fort Worth Outpatient Clinic and another had scheduled a future appointment. The other four veterans had not received care and had no appointments scheduled.

Conclusion Means testing activities should be strengthened to prevent Privacy Act violations and to ensure that patients required to make co-payments are identified.

Recommendation 15 The System Director should provide refresher training for personnel responsible for administering means tests and conduct periodic reviews to monitor compliance with means test criteria.

System Director's Comments

Concur.

Training of new and existing staff has already begun. Additionally, a new position (Means Test Coordinator) has been created and is now filled. This position will be responsible for the training and monitoring of the Means Test process on a daily basis.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Controls Over Time and Attendance Reporting Could Be Improved

VA Manual MP-6, Part V, Supplement 2.2, Chapter 1, states that a unit timekeeper or alternate timekeeper generally will not be permitted to maintain his/her own time and attendance report. Exceptions may be made where this is an impractical requirement due to such factors as a lack of clerical personnel or leave status of the unit timekeeper or alternate. Also, each facility is required to conduct annual refresher training for all unit timekeepers.

Timekeepers at the System maintained their own time and attendance records. We reviewed the time and attendance records for 10 unit timekeepers for the pay period beginning February 13, 2000, and found that 9 of the 10 timekeepers input their own time and attendance reports. This did not appear necessary since all but one of the units had alternate timekeepers who could have maintained the records of the unit timekeepers. Three of the timekeepers who input their own reports were paid overtime during the pay period. We did not determine that anyone was paid for overtime that was not worked. However, some of the overtime reported by these three employees took place outside the normal duty hours of the supervisors who certified the time and attendance reports.

Timekeepers did not receive required annual training. Interviews with payroll unit personnel and a review of training documentation disclosed that newly assigned

timekeepers received training. However, refresher training for other timekeepers had not been provided since April 1997.

Conclusion To ensure that time and attendance is reported accurately and independently, alternate timekeepers should maintain the time and attendance records of unit timekeepers whenever practical. Annual training should be provided to ensure that timekeepers are familiar with current requirements governing employee time and attendance.

Recommendation 16 The System Director should ensure that timekeepers do not maintain their own time and attendance records except when alternatives are not practical. Provide annual refresher training for timekeepers.

System Director's Comments

Concur.

Timekeeper training was conducted April 26, 2000 for current timekeepers and alternate timekeepers to reiterate the requirements outlined in VA Manual MP-6, Part V, Supplement 2.2, Chapter 1, regarding the prohibition of maintaining their own time card.

New timekeepers and alternate timekeepers appointed throughout the year will be informed of pertinent regulatory requirements regarding their duties and responsibilities. The training for timekeepers and alternate timekeepers has been initiated and will be conducted at least on an annual basis in order to provide appropriate information and guidance.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Obligations Should Be Reviewed More Effectively

VA Manual MP-4, Part V, Chapter 3, requires monthly reviews of accrued services payable and undelivered orders which appear to have been outstanding for an unreasonable length of time. Accrued services payable are obligations established to pay the estimated cost of services contracted for but not yet received. Typical accrued services payable include obligations to pay costs of utilities and recurring maintenance contracts. Undelivered orders are obligations established to pay for supplies that have been ordered. Accounting personnel must review these open obligations to determine whether the funds are still needed. As of December 31, 1999, the System had 2,135 accrued services payable totaling $76.2 million, and 1,525 undelivered orders totaling $25.1 million.

We reviewed 29 obligations which were more than 90 days old as of December 31, 1999, to determine whether the obligations were still needed. Our judgment

sample included 15 accrued services payable totaling $85,679 and 14 undelivered orders totaling $126,726. We found that 5 accrued services payable totaling $32,613 and 4 undelivered orders valued at $1,052 were no longer needed.

Conclusion To improve funds management, accounting personnel should conduct more effective reviews of accrued services payable and undelivered orders. Funds that can be deobligated should be identified as soon as possible so they can be put to better use.

Recommendation 17 The System Director should strengthen reviews of outstanding accrued services payable and delinquent orders.

System Director's Comments

Concur.

A procedure is in place to review accrued services payable and undelivered orders on a monthly basis. Efforts will be made to strengthen these reviews and to deobligate the funds that are no longer needed.

Office of Inspector General's Comments

The System Director's implementation plan is acceptable and we consider the issue resolved.

Appendix I

Fraud and Integrity Awareness Briefings

An OIG Special Agent in Charge conducted four fraud and integrity briefings. Forty-three individuals from various services in the System 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 certainly 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 this reason, all contacts with the OIG to report such instances are handled as confidential contacts.

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 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 have 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 titles, 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, 2000. 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, 1999."

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.

Appendix I

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 the OIG and were encouraged to call and discuss any concerns regarding the applicability of bringing a particular matter to the attention of the OIG.

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

MONETARY IMPACT IN ACCORDANCE WITH IG ACT AMENDMENTS

REPORT TITLE: **COMBINED ASSESSMENT PROGRAM REVIEW VA North Texas Health Care System**

PROJECT NUMBER: **2000-01065-R5-0210**

Recommendation	Category/Explanation of Benefits	Questioned Costs	Recommended Better Use of Funds
17	Better Use of Funds: Deobligating unneeded accrued services payable and undelivered orders would make funds available for other uses.	--------	$33,665

SYSTEM DIRECTOR'S COMMENTS

August 7, 2000

Director (00), VA North Texas Health Care System

Draft Report – Combined Assessment Program Review

Assistant Inspector General for Auditing (52)

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) Review during the period of February 28 – March 3, 2000. VA North Texas Health Care System (VANTHCS) was appreciative of the constructive approach taken by each member of the OIG team during this review. The review proved to be informative and has provided VANTHCS recommendations that will further improve quality care and service to our veterans.

2. Attached is the VANTHCS reply to the subject draft report. If you should have any questions, please contact Mr. Michael S. George, Chief, Quality Management Service at (214) 857-0484.

(original signed by)
Alan G. Harper

Att.

NOTE: VANTHCS response has been incorporated into the report under the heading: System Director's Comments.

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This report will be available in the near future on the VA Office of Audit web site at http://www.va.gov/oig/52/reports/mainlist.htm List of Available Reports.