Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of VA Medical Center Denver, Colorado

Report No. 00-00473-63
Date: May 4, 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 financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

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

Combined Assessment Program Review of VA Medical Center Denver, Colorado

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Denver, Colorado. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care quality management (QM) and financial and administrative management controls. During the review we also provided Fraud and Integrity Awareness training for about 100 VAMC employees.

VAMC Denver is a 226-bed tertiary care facility, providing a full range of medical, surgical, psychiatric, and nursing home care services. The VAMC's Fiscal Year (FY) 2000 budget is $134.6 million and staffing is about 1,278 employees. In FY 1999, the VAMC's workload was 33,107 unique patients treated, 6,290 inpatient admissions, and 287,883 outpatient visits.

Patient Care Quality Management. VAMC management had created an environment that supported quality management and performance improvement. The VAMC had a comprehensive, well-organized QM program that effectively coordinated patient care activities and provided strong oversight of the quality of care. We made one recommendation for VAMC management to review and take appropriate action on various patient care issues and concerns, including (a) securely storing and properly labeling medications; (b) correcting potential safety hazards in a psychiatric unit; (c) improving medication error data collection; and (d) performing tuberculosis screening for certain high-risk patients.

Financial and Administrative Management. The VAMC's financial and administrative activities were generally operating satisfactorily and controls were generally effective. To improve controls, we recommended that the VAMC: (a) obtain better pricing data and improve performance monitoring for clinical services contracts; (b) transfer purchase card coordinator duties; (c) reduce supply inventories; (d) include expired drugs in controlled substances inspections; (e) pursue collection of delinquent accounts receivable; (f) improve reviews of unliquidated obligations; and (g) strengthen information technology security by providing training to employees and by designating an alternative computer processing site.

Medical Center Director Comments. The VAMC Director concurred with the recommendations and provided acceptable implementation plans. (See Appendix III for the full text of the Director's comments.) We consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

(Original signed by:)
RICHARD J. GRIFFIN
Inspector General

Table of Contents

Introduction

VA Medical Center Denver

VAMC Denver is a highly affiliated facility providing tertiary medical, surgical, psychiatric, and nursing home care. Outpatient care is provided at the VAMC and at a primary care clinic located at the former Fitzsimmons Army Medical Center in nearby Aurora, Colorado. The VAMC is one of seven medical centers in Veterans Integrated Service Network (VISN) 19. The VAMC's primary service area includes metropolitan Denver and 25 contiguous counties in Colorado and western Nebraska. The veteran population in the service area is 326,000.

Programs. The VAMC has 166 acute care beds and 60 nursing home beds and operates a wide range of specialty medical programs such as cardiac surgery and nuclear medicine. In Fiscal Year (FY) 1999, the VAMC's medical research program had 200 active projects and a budget of $13.6 million. The VAMC serves as a referral hospital for other VISN 19 facilities and provides some services to the U. S. Air Force Academy and Evans Army Hospital, which are located in Colorado Springs, Colorado.

Affiliation. The VAMC is affiliated with the University of Colorado medical, dental, pharmacy, and nursing schools and supports 119 medical resident positions in 38 training programs. Clinical training rotations are also provided for about 450 medical students and about 370 nursing students.

Resources. The FY 2000 budget is $134.6 million, 7.6 percent more than the FY 1999 expenditures of $125.2 million. FY 1999 staffing totaled 1,277.7 full-time equivalent employees (FTEE) and included 96.4 physician FTEE and 379.3 nursing FTEE.

Workload. In FY 1999, the VAMC treated 33,107 unique patients, a 9.5 percent increase from FY 1998. The inpatient care workload included 6,290 admissions and an inpatient average daily census of 144. The outpatient care workload was 287,883 visits.

Objectives and Scope of CAP Review

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

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

inspected patient care areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. We also used questionnaires and interviews to survey employees and patient opinions and perceptions about quality of care and various other matters, such as waiting times and satisfaction with care received.

Financial and Administrative Management Review. Office of Audit staff reviewed selected administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, to prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed management and staff, and reviewed pertinent administrative, financial, and clinical records. The review covered the following 15 financial and administrative activities and controls:

- Construction Planning
- Ambulance Contracts
- Agent Cashier Operations
- Surgical Resident Supervision
- Clinical Services Contracts
- Purchase Card Program
- Supply Inventory Management
- Controlled Substance Inspections
- Accounts Receivable
- Unliquidated Obligations
- Information Technology Security
- Equipment Procurement and Accountability
- Pharmacy Security
- Medical Care Cost Fund
- Payroll and Timekeeping Controls

Fraud and Integrity Awareness Training. Office of Investigations special agents conducted two Fraud and Integrity Awareness Briefings for VAMC employees. About 100 employees attended these briefings. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review covered VAMC operations for FY 1999 and the first quarter of FY 2000 through November 1999. The review was done in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

Results and Recommendations

Patient Care Quality Management

Patient Care Quality Management Was Generally Effective

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

Top Management Showed Commitment to Quality Management. The VAMC's top management team had demonstrated a strong commitment to quality management and performance improvement. Top management had supported continuing education for staff in such areas as performance improvement, total 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. For example, the Director personally reviewed all patient complaints and ensured an appropriate and positive response by VAMC staff. Top managers also conducted daily tours of different areas of the VAMC to observe operations and talk with employees.

The QM Program Was Comprehensive and Well Organized. The Office of the Director's QM Section was providing direction, coordination, and oversight for the VAMC's quality management program. This comprehensive program included such activities as utilization review, total quality management, risk management, administrative boards of investigation, and the patient representative program. Our review found that quality management staff were effectively tracking results of and ensuring appropriate follow-up for patient incident reports, root cause analyses, and administrative investigations.

Most Patients and Employees Were Satisfied with Quality of Care. We interviewed VAMC top management, 83 clinical managers and staff, and 258 patients. We also sent survey questionnaires to 251 randomly selected full time employees with 161 (64 percent) providing responses. The results of our survey and interviews showed that VAMC employees and patients were generally satisfied with the quality of care provided by the medical center. For example, 84 percent of patients, 77 percent of clinicians, and 80 percent of managers rated the quality of care provided to patients as good, very good, or excellent. Similarly, 79 percent of patients, 74 percent of clinicians, and 80 percent of managers rated their overall satisfaction with treatment as good, very good, or excellent.

Management Should Address Various Patient Care Environment and Oversight Issues

During the review, we noted a number of patient care environment and oversight issues and concerns that did not require individual recommendations but that collectively warranted management attention.

Patient Care Environment

Medication Storage and Labeling. Our inspections of VAMC clinical areas found three instances of medications not being properly stored. In the Imaging Service, contrast materials that should have been secured like other medications were stored in an unlocked room that could be easily accessed by numerous VAMC employees. In the Emergency Room's medication room we found an unlabeled plastic dish containing a substance that staff said was a powdered drink mix used to treat patients experiencing hypoglycemic episodes. The container did not have mixing instructions and nursing staff gave different descriptions of how the drink should be mixed. We also found medications on a cart located in an open, unlocked outpatient clinic room. Clinical managers should ensure that all medications are securely stored and properly labeled.

Inpatient Psychiatric Unit Safety. Our inspection of the inpatient psychiatric unit (ward 7 East) identified four potential hazards requiring review and possible corrective action. We found metal hooks suspended from a non-breakaway track on a shower room door. Sprinkler heads were not recessed, and unit staff did not know if the heads were breakaway types or not. Screws securing a wall bracket were not recessed, which makes them easier to remove. Plastic sheeting secured by duct tape was being used to partition off areas undergoing renovation. These potential hazards might make it easier for unstable patients to attempt suicide or to otherwise injure themselves, other patients, or staff. Facilities Management Service should review these potential hazards and replace or remove any components found to be unsafe.

Restroom and Shower Cleaning and Maintenance. Our inspection of clinic and public spaces found that most areas were clean and adequately maintained. However, we identified several restrooms and showers that were not clean or properly maintained. The public restrooms in the Physical Medicine and Rehabilitation Outpatient Clinic area were dirty, rubbish containers were overflowing, and soap and paper towel dispensers were empty. A women's shower room in one inpatient unit (ward 5 South) was dirty and was being used to store equipment. Only one women's restroom, which was located in a busy area next to the Canteen, had a feminine hygiene product dispenser. We found the dispenser empty on two consecutive days. In addition, the VAMC did not have diaper-changing stations in public restrooms. (We saw a number of infants and toddlers accompanying patients and visitors.)

VAMC management had been giving ongoing attention to housekeeping issues. They acknowledged that keeping all areas clean was sometimes a problem because of difficulties in filling housekeeping positions and because of several large construction and renovation projects in progress. Facilities Management Service should ensure that housekeeping staff inspect, clean, and restock restrooms and showers at appropriate intervals. To better meet the needs of patients and visitors, VAMC management should have feminine hygiene dispensers placed in women's restrooms throughout the medical center and should explore the feasibility of placing diaper changing stations in restrooms.

Storage of Housekeeping Cleaning Agents. While inspecting clinical areas we identified two instances of improperly stored cleaning agents and chemicals. A second floor housekeeping closet was unattended and the door latch had been obstructed to prevent it from closing and locking. The closet contained a variety of potentially hazardous chemical cleaning agents that

should always be kept secure from possible access by patients and other unauthorized persons. We notified ward staff who locked the closet. However, later that day we again found that the closet door was open and obstructed from closing. In addition to this instance, we found cleaning chemicals stored in a restroom in the Physical Medicine and Rehabilitation Clinic. Facilities Management Service managers should ensure that housekeeping staff keep unattended closets locked and store cleaning agents only in secured areas.

Latex-Free Products. Our employee interviews indicated that some clinical staff were not familiar with latex-free products such as examination gloves that could be dispensed to employees and patients with latex allergies. Some staff did not know what latex-free products were available at the VAMC or where in clinical areas the products were stored. In addition, some employees did not seem aware of the potential risks that latex allergies present to patients. To improve employee awareness of latex allergy issues, the Director should ensure that appropriate training is provided to familiarize clinical staff with the risks of latex allergies and with the availability of latex-free products.

Surgical Intensive Care Unit Access. The Surgical Intensive Care Unit's (SICU) hallway was extremely cluttered with equipment, tables, and chairs that interfered with access to the area. Nursing staff used the tables and chairs as desks while monitoring patients. A planned SICU remodeling project may not adequately address the cluttered condition. Facilities Management Service and unit staff should explore alternatives for storing equipment that would eliminate the clutter. In addition, the renovation plans should be reviewed and modified as appropriate, such as by adding built-in desks and by providing adequate storage space.

Placement of Warning Signs. The Emergency Room waiting area contained warning signs alerting patients who experience chest pain, shortness of breath, or bleeding to immediately notify an employee. However, the signs had been placed under the ledge of the sign-in desk where they were difficult for patients to read. To better ensure that patients can see the warnings, the signs should be moved to more visible locations in the waiting area.

Patient Care Oversight

Medication Error Data Collection. The VAMC's quality management data collection processes did not effectively ensure that information for all reported medication errors would be forwarded for inclusion in VAMC-wide trend analyses and summary reports. Generally, the Nursing and Pharmacy Services received and analyzed most medication error reports and forwarded the results of their reviews to the QM Section. However, it did not appear that the reporting processes would ensure that information about medication error reports originating in other clinical activities would be forwarded for inclusion in VAMC summary reports. To better ensure more systematic and comprehensive medication error data collection and analysis, the QM Section should delineate the steps and routing to be followed by all clinical activities in collecting and forwarding medication error information.

Tuberculosis Screening. Tuberculosis (TB) screening needed to be improved to ensure coverage of certain high risk patients. Based on interviews with clinical staff and our review of performance improvement records and other reports, TB screening was not routinely or

consistently performed for three categories of patients: patients admitted to the inpatient psychiatric units, participants in the outpatient substance abuse treatment program, and patients admitted to the nursing home care unit (NHCU). Responsible clinical staff should ensure that TB screening is included in the patient assessment and treatment guidelines and is routinely performed for these patients.

Post-Injection Patient Observation. Injection Clinic policy required patients to wait in the medical center atrium for 20 minutes after receiving allergen or inoculation injections so that allergic reactions or other complications could be identified and treated. However, Injection Clinic staff did not actively check on the patients during this waiting period. Instead, patients were instructed to return to the Injection Clinic or go to the Emergency Room if they developed shortness of breath or other reactions. However, some patients experiencing reactions might not be physically able to return to the clinic and might not be accompanied by someone who could seek assistance for them. To improve post-injection observation practices, Injection Clinic staff should be required to actively check on patients during the waiting period.

Vital Signs Screening Checklist. In several clinics volunteers helped check in patients by recording information such as the reason for the visit and by taking and recording patient vital signs, such as pulse rate, temperature, and blood pressure. When performing this screening process, volunteers are supposed to follow the guidelines in the VAMC's volunteer orientation plan and checklist. These guidelines instruct the volunteer to immediately notify a nurse or physician if vital signs are not within certain parameters, such as a pulse rate of less that 40 beats per minute, or if the patient has a serious complaint, such as chest pains. Although the orientation plan and checklist provided good guidance to volunteers, the list of conditions and vital sign readings that required immediate notification of clinical staff should be expanded by adding two conditions to the list -- bleeding and a pulse rate exceeding a clinically determined maximum level such as 120 beats per minute.

Sexual Assault Treatment Protocol. The VAMC's protocol for treating patients who are victims of sexual assault was thorough. However, the protocol was aimed at treating women patients and did not specifically address male sexual assault victims. To better ensure that the clinical needs of all potential patients are met, the sexual assault treatment protocol should be revised to cover male patients.

Medical Record Documentation. Our review of 37 randomly selected medical records found that some improvement was needed in the documentation of patient education, patient risk assessment, and treatment goals. In two of six outpatient records reviewed, the file did not contain documentation of patient education for issues such as medication use or preventative care. None of the 25 inpatient records reviewed contained documentation that clinicians had assessed the patient's risk for falls, elopement, or nutritional needs. Our review of six records for current nursing home patients found that the patient assessment process was generally effective and well documented. The records contained weekly, monthly, and quarterly progress notes completed by clinical staff in the various treatment disciplines. However, none of the six records contained documentation of measurable treatment goals. Two of the six nursing home patient records reviewed did not contain evidence of timely review of a history and physical (H&P) examination by the responsible clinician. One record did not have a documented review by a

NHCU clinician to determine if an H&P examination completed during a previous acute inpatient episode of care would meet clinical information needs for the current nursing home admission. To reinforce medical records documentation requirements, the QM Section should issue reminders that should be used in clinical staff training sessions.

Feedback on Use of Restraints. The VAMC had developed protocols covering the proper use of restraints, including their use in the intensive care units (ICUs). ICU use of restraints is reported to VAMC management each day in the morning report and this information is compiled by the nursing compliance officer. However, summary information is not systematically provided to ICU managers and staff for their use in assessing outcomes. To better ensure that ICU staff receive feedback on the use of restraints, the compliance officer should periodically provide, such as on a quarterly basis, summary information on restraint use to ICUs.

Nursing Home Medication Reports. Pharmacy Service had routinely prepared comprehensive monthly reports on NHCU medication use. According to NHCU staff, the reports had provided useful information for monitoring and analyzing nursing home patient medication use, including the use of psychotropic and other high-risk drugs, medication costs, and clinician prescribing patterns. However, the reports were discontinued in April 1998. To ensure nursing home patient medication use is adequately monitored, Pharmacy Service should resume providing comprehensive monthly medication reports to the NHCU.

Outcome Measures for Substance Abuse Treatment and Homeless Programs. The Mental Health Service had not developed outcome measures, such as the number and percent of patients meeting treatment program goals, and had not collected outcome data to use in evaluating the effectiveness of the outpatient Substance Abuse Treatment and Homeless Veteran Programs. To ensure that treatment program effectiveness is evaluated, the Mental Health Service should develop outcome indicators and begin collecting measurement data for these two programs.

Recommendation 1. The VAMC Director should ensure that the issues and concerns discussed above are reviewed and that corrective action is taken as warranted and feasible.

Medical Center Director Comments. The VAMC Director concurred with the recommendation and indicated that the issues cited would be referred to the appropriate VAMC officials for corrective action as warranted. Written reports will be prepared to document the assessment of the issues and the corrective actions taken.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Financial and Administrative Management

Management Controls Were Generally Effective

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

Construction Projects Were Properly Planned. As of December 1999, the VAMC had begun or planned to begin 10 construction projects. We reviewed the justifications for these projects and inspected the areas affected by the planned construction. We concluded that all 10 projects were well planned, had been properly justified, and were needed to correct significant space and functional deficiencies. The largest ongoing project was the construction of an $11.8 million, 700-space parking garage. This project was clearly needed to correct a severe parking shortage. The VAMC had two minor construction projects (cost = $3.4 million) to add floors to the main hospital's E wing to provide permanent space for VAMC functions now housed in leased space. The remaining seven projects were nonrecurring maintenance projects (cost = $7.2 million) to renovate hospital entrances and wards, to replace elevators and air conditioning units, and to improve signage.

Air and Ground Ambulance Contracts Were Properly Awarded and Administered. In FY 1999, the VAMC improved controls on patient transportation authorizations. This reduced air and ground ambulance costs by $400,263, from $989,815 in FY 1998 to $589,552 in FY 1999. The VAMC had one ground ambulance contract and one air ambulance contract. We reviewed records for both contracts and concluded that contract prices were reasonable and that both contracts had been properly awarded through open competition. We also reviewed a judgment sample of 10 ground and air ambulance invoices and their associated requests for patient travel authorizations. All 10 invoices were supported by properly completed and approved authorizations, and the VAMC paid the correct contract rates on all 10 invoices.

Agent Cashier Operations Were Sound. Our review of Agent Cashier operations found no deficiencies. We requested and observed an unannounced audit of the Agent Cashier. VAMC staff conducted the audit properly. The audit found no overages or shortages in the Agent Cashier advance. We analyzed recent cash disbursements and concluded that the amount of the cash advance was appropriate. Agent cashier security was adequate, and the combinations to the Agent Cashier's and the alternate Agent Cashier's safes had been properly secured.

Surgical Residents Were Properly Supervised. To determine if the supervision of surgical residents met VA requirements, we reviewed the Attending Surgeon Report for November 1999. We concluded that resident supervision complied with VA policy. During the month reviewed, 254 surgical procedures were performed. For 188 procedures (74.0 percent), attending surgeons provided Level I or Level II supervision, which meant that the attending was in the operating rooms (171 procedures) or in the operating room suite (17 procedures). In the remaining 66 cases, attending surgeons provided Level III supervision, which meant that the attending was available but not present. In all these 66 cases, senior resident teaching assistants were present to

supervise junior residents. For all procedures reviewed, levels of supervision provided were consistent with the complexity of the procedures and with the post-graduate year experience of the residents involved.

Recommendations for Improving Management Controls

Clinical Services Contracts -- Obtaining Cost or Pricing Data Will Ensure that Contract Prices Are Reasonable

The VAMC had 12 noncompetitive clinical services contracts valued at $3.4 million. When VAMCs contract noncompetitively for clinical services, they should develop sufficient pricing information to ensure that contract prices are reasonable (and this information should be retained in the contract file). For procedure-based contracts, the price benchmark is Medicare rates. For FTEE-based contracts with affiliated institutions, the benchmark is the salary and benefits cost that the institution incurs to provide the services. As part of contract negotiations, VAMCs should obtain the necessary cost information from the affiliate. For both procedure-based and FTEE-based contracts, prices should not exceed the benchmarks unless justified by unusual circumstances.

To determine if the VAMC had negotiated reasonable prices for contracted clinical services, we reviewed the five largest contracts (value = $2.7 million), which were used to purchase various services from the affiliated university. In performing the review, we examined contract files and interviewed contracting officers and contracting officer technical representatives (COTRs). Of the five contracts, two were procedure-based (cardiothoracic surgery and liver/lung/transplants) and three were FTEE-based (anesthesiology, neurosurgery, and orthopedic surgery).

Cost Data Not Obtained for FTEE-Based Contracts. The prices negotiated for the two procedure-based contracts were at or below Medicare rates and were therefore reasonable. However, for the three FTEE-based contracts VAMC staff had not obtained salary and benefits cost data from the affiliate and therefore did not have adequate assurance that contract prices were reasonable. The contract files did not contain any documentation showing how the contract prices had been reached. To correct this problem, during the CAP review VAMC staff obtained the necessary cost data from the affiliate. We reviewed this data and concluded that contract prices were in line with the affiliate's cost. To ensure that prices on future FTEE-based contracts are also reasonable, the VAMC should strengthen its contracting procedures to require the obtaining of cost data before contract negotiations begin.

Price Negotiation Memorandums Not Completed. After contract negotiations are completed, the contracting officer should prepare a Price Negotiation Memorandum (PNM). The purpose of the PNM is to provide documentation of the most important elements of the contract negotiation process, including the purpose of the negotiations, a description of the services being procured, and an explanation of how contract prices were determined. PNMs had not been done for any of the five contracts reviewed.

Anesthesiology Contract Performance Not Monitored. For all clinical services contracts, a COTR should monitor contractor performance to ensure that services are being provided in accordance with contract terms (VA Acquisition Regulations 837.205). Monitoring was

effective for four of the five contracts. However, monitoring had not been done for the anesthesiology contract. During the review, the COTR developed performance data for this contract. We reviewed this data and concluded that the VAMC had received the level of service paid for.

Recommendation 2. The VAMC Director should ensure that: (1) appropriate salary and benefits data is obtained to support the prices negotiated for FTEE-based contracts; (2) PNMs are completed for all contracts and included in contract files; and (3) performance is monitored on all contracts.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. As of January 2000, the Acquisition and Materiel Management Service (A&MMS) had modified contracting procedures to require that contracting officers obtain the necessary cost data and complete the required PNMs. VAMC staff are now monitoring performance on all contracts. For future contracts, contracting officers will ensure that COTRs have established effective monitoring procedures.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Purchase Card Program -- Coordinator Duties Should Be Transferred

VAMCs generally use commercially issued purchase cards for small purchases of goods and services (usually $2,500 or less per order). VHA policy requires VAMCs to establish adequate internal controls to ensure that items purchased are actually received, that charges are for official purposes, that bills are correctly paid, and that conflicts of interest are avoided in the administration of purchase card activities.

As part of the internal control requirements, cardholders should reconcile payment charges listed on a report provided by the purchase card contractor with the purchase accounts recorded in VHA's financial system, IFCAP (Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System). Reconciliations should be completed within 5 days of the IFCAP message confirming VA payment to the contractor. Approving officials should certify the reconciled purchase transactions within 14 days of receipt from the cardholder. We reviewed cardholder transaction reconciliations and approving official certifications of purchase card transactions occurring from June 1, 1999, to November 30, 1999, and found that both reconciliations and certifications were generally completed on time. During the 6-month period reviewed, cardholders processed 8,343 transactions with a total value of $4.9 million. Of those transactions, only 990 (11.9 percent) were not reconciled by cardholders within 5 days and only 31 (0.4 percent) were not approved by certifying officials within 14 days.

We identified one issue that management needed to address -- the purchase card coordinator was also a purchase card holder and an approving official for 50 other cardholders. This is not allowed by VHA policy, which states that the coordinator "cannot be a cardholder or [an] approving official" (VHA Directive 1730.1 (2) (e)). This policy is grounded in the internal control principle of segregation of duties -- that is, to reduce the risk of error or fraud, the key

duties of authorizing, processing, and reviewing transactions should be segregated among different employees. Since the purchase card coordinator is responsible for the overall implementation of the program, including monitoring cardholders and approving officials, the coordinator should not be a cardholder or an approving official. We did not find any indication that the coordinator had made or approved any inappropriate transactions. However, to ensure adequate segregation of duties and to avoid any appearance of conflict of interest, the coordinator's duties should be transferred to an employee who is independent and not involved in the day-to-day use of purchase cards.

Recommendation 3. The VAMC Director should transfer the coordinator's duties to an employee who does not have a purchase card and who does not approve purchase card transactions.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. In January 2000, the purchase card coordinator's duties were transferred to the A&MMS Administrative Officer.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issue to be resolved.

Supply Inventory Management -- Stock Levels Were Reasonable but Controls Could Be Enhanced

We evaluated the VAMC's management of prosthetics, pharmacy, and medical supply inventories to determine if controls were adequate to prevent the build-up of excess inventory. Inventories should contain sufficient supplies to meet current operating needs, and purchases above this level should be avoided so that funds are not tied up in excess inventory. The demand for most supply items can be met by maintaining inventories at no more than 30-day levels. If supplies are purchased from a prime vendor, stock levels should be less than 30 days because prime vendors provide just-in-time delivery (typically next day). In recent years, VHA has encouraged VAMCs to modernize inventory management by utilizing VA's automated inventory management systems. In addition, VHA has encouraged the use of other modern inventory management tools such as barcoding, prime vendors, and automated replenishment ordering.

The VAMC had established generally effective inventory controls, and we found no significant excess inventories of prosthetics, pharmacy, or medical supplies. The VAMC services responsible for these inventories were using the modern inventory techniques recommended by VA policy. Prosthetics Service used the Prosthetics Inventory Package (PIP) to manage inventory. Since PIP does not capture the value of stock on hand, the service had developed its own automated program to accomplish this. Pharmacy Service purchased supplies from a prime vendor and made extensive use of bar-coding and purchase history reports in managing their inventory. Acquisition and Materiel Management Service used the Generic Inventory Package (GIP) to manage medical supply inventories stored in the warehouse and in the Supply Processing and Distribution (SPD) Section. Supplies in both the warehouse and SPD were barcoded. Most notably, A&MMS used a prime vendor to purchase most medical supplies. This

had significantly reduced both the number of supply items in inventory and the stock levels of these items.

Our review identified two opportunities to enhance inventory management. First, Pharmacy Service could realize the full benefit of the prime vendor contract by further reducing inventory levels. Second, A&MMS could improve the accuracy of GIP data for medical supplies.

Pharmacy Stock Levels. Pharmacy Service had informally set stock levels at 14 days. We reviewed the stock levels of 10 high cost drugs and found that levels for 5 drugs were 14 days or less (range = 1 to 14 days) and that levels for the other 5 drugs were more than 14 days (range = 15 to 40 days).

According to Pharmacy Service management, the higher stock levels for some drugs were attributable to fluctuations in the usage of these drugs. However, one benefit of purchasing from a prime vendor is that usage fluctuations can be managed with lower inventory levels. Pharmacy Service could safely establish lower stock levels because if there was an unexpected increase in usage for a particular drug the prime vendor could usually deliver an additional supply within 1 day. To take full advantage of the services offered by the prime vendor, Pharmacy Service should incrementally, but systematically, reduce the stock levels of all high cost drugs that have more than 14 days of stock on hand. Once this is accomplished, the service should work toward reducing the overall inventory stock level to 10 days, which is a safe and efficient level for most drugs given the just-in-time service provided by the prime vendor.

Accuracy of GIP Data. To test the accuracy of GIP inventory records, we performed a physical inventory of a sample of 10 items stocked in SPD and/or in the warehouse. We then compared the quantities shown in GIP to our actual physical count. GIP inventory records were not accurate for 6 of the 10 items:

- For 3 of the 6 items transactions had been inaccurately or incompletely posted to inventory records (one issue from the warehouse and two returns to SPD). This resulted in inventory balances being understated or overstated for the items in question.

- For 2 items, staff recorded in GIP receipts for supplies ordered for services that did not have inventory control points but did not record issues to these services. This overstated the SPD inventory.

- For 1 item that was reusable, SPD staff recorded it in GIP as an expendable item. This overstated the quantity on hand for the item. This problem occurred because SPD had not fully implemented the GIP surgical case cart system. This system is designed to facilitate the assembly of and inventory tracking of reusable items and expendable supplies contained in surgical carts, procedure trays, and instrument kits.

During our review, SPD staff told us that another problem in keeping GIP data accurate was that ward staff on the evening and weekend shifts sometimes took supplies from the wards from SPD without accurately recording the transactions for the supplies taken. These transactions should be recorded on a sign-out form (the "call down sheet"). We reviewed sign-out forms covering several weeks and confirmed that transaction entries were sometimes incomplete or inaccurate.

Inappropriate, incorrect, or untimely postings to GIP result in inaccurate inventory balances. If inventory balances are not kept current, GIP cannot accurately track item demand, which must be known in order to establish reasonable stock levels and reorder points. Inaccurate inventory information also limits the effectiveness of other GIP features, such as the autogeneration of replenishment orders.

Recommendation 4. The VAMC Director should ensure that: (a) Pharmacy Service reduces drug inventory stock levels, with a 10-day level as the goal; (b) A&MMS provides refresher training on the need to promptly and accurately record inventory transactions to all staff, including ward staff, who are involved in issuing and/or distributing supplies; (c) A&MMS completes implementation of the case cart system; and (d) A&MMS brings SPD's GIP data up to date after implementation of the case cart system.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. In February 2000, Pharmacy Service began a project to reduce inventory levels by reviewing and reducing as needed the levels of the 20 highest per unit cost drugs that have had fluctuations in usage. When the requirements for these drugs are successfully managed, Pharmacy Service will continue to reduce stock levels and try to achieve the 10-day goal for most drugs. The VAMC has begun scheduling education for all staff involved in inventory transactions. The initial education was completed by March 2000. When the drug accountability software is operational, additional inventory management practices will be implemented. By July 2000, A&MMS will complete implementation of the case cart system and will bring the SPD GIP data up to date.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Controlled Substances Inspections -- Expired Drugs Should Be Included in Inspections and Drug Cabinets Should Be Locked

VAMCs are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The purpose of these inspections is to ensure that controlled substances are properly accounted for. The inspectors must be VA employees who do not work in the Pharmacy Service. Inspectors should physically count the quantities of controlled substances on hand and reconcile these quantities to perpetual inventory records. As part of our review, we requested and observed a surprise inspection of selected areas where controlled substances were stored and dispensed. We also reviewed records of the inspections done for the 12-month period December 1998 to November 1999. Both our surprise inspection and the prior inspections found good accountability for controlled substances.

We noted only one inspection issue -- the inspection procedures did not cover excess, outdated, or unusable controlled substances that were stored in the pharmacy vault until they could be destroyed. VHA policy requires that inspections include these drugs (VHA Handbook 1108.2). Under Pharmacy Service procedures, unusable drugs were removed from inventory and stored in a drawer of a Pyxis unit in the pharmacy vault. (The Pyxis unit is a narcotics distribution system that allows only users with personal identification codes to access the drugs.)

VAMC procedures did not require the stored drugs to be covered by the unannounced inspections because Pharmacy Service performed their own inspections once or twice a month. However, to ensure independent oversight of stored drugs and to comply with VHA policy, these drugs should be included in the unannounced inspections.

We identified one security issue that should be addressed. During the inspection of the Injection Clinic, we observed controlled substances in an unlocked cabinet located in an unattended office with the door ajar. Unescorted patients were in the hallway near the office. Immediately after we observed this, the employee responsible for keeping the cabinet locked was counseled.

Recommendation 5. The VAMC Director should (1) ensure that excess, outdated, and unused controlled substances are included in monthly inspections and (2) ensure Inspection Clinic staff keep controlled substances properly secured at all times.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. As of February 2000, all monthly unannounced inspections include the review of all controlled substances set aside for destruction. Injection Clinic staff have been educated regarding proper security and accountability of controlled substances. Review of clinic staff compliance with daily inventory procedures will be conducted during monthly inspections.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Accounts Receivable -- Delinquent Debts Should Be Pursued

VA policy requires that accounts receivable owed to the VAMC be accurately recorded in accounting records, reconciled to the general ledger each month, and collected promptly (VA Manual MP-4, Part V). Our review found that accounts receivable were properly recorded and reconciled. However, improvement was needed in the collection of delinquent receivables.

At least once each quarter Fiscal Service staff should review the "Verification of General Ledger Balances -- Accounts Receivable" report to identify receivables that are more than 90 days old. These delinquent receivables should be analyzed to determine whether they should be pursued or written off. Receivables that have recovery potential should be aggressively pursued through the use of collection letters and telephone calls. During our review, Fiscal Service staff acknowledged that they had not been identifying and pursuing delinquent receivables.

As of October 31, 1999, the VAMC had 154 receivables valued at $187,068. Of these, 113 (73.4 percent) with a value of $125,442 (67.0 percent of the total value) were more than 90 days old. To evaluate the collection potential for these receivables, we reviewed 15 of the larger receivables with a total value of $41,965. Based on discussions with Fiscal Service staff, we concluded that of the 15 receivables, 10 with a total value of $32,456 had good collection potential:

- Six receivables valued at $22,456 were for laboratory and pathology services that the VAMC sold to hospitals and other medical providers in the Denver area.

- Four receivables valued at $10,000 were for clinical or research services that the VAMC provided to the affiliated university.

In addition to these 10 collectible receivables, we identified 31 receivables valued at $20,068 that the Air National Guard owed the VAMC for services provided to Guard personnel. Fiscal Service had pursued these debts by letter and by telephone. However, according to the Chief of Fiscal Service these efforts had been unsuccessful because the Guard had disagreed with the VAMC's method of calculating charges. No further efforts had been made since April 1999. Pursuit of these debts should be continued, if necessary by VAMC management working with Guard Management to resolve the issue.

Recommendation 6. The VAMC Director ensure that (a) Fiscal Service establishes effective controls for identifying and pursuing delinquent receivables and (b) the delinquent receivables identified by our review are pursued.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. As of January 2000, the Business Office has established procedures to aggressively pursue receivables and to review delinquent receivables every 90 days. An accounting technician will call on all receivables that are open longer than 90 days and request payment. As of February 2000, the VAMC requested guidance from headquarters regarding additional measures to be taken to collect monies owed by the Air National Guard, including a request for a billing contact within DoD at a higher level than the local Guard contact.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Unliquidated Obligations -- Unneeded Obligations Should Be Promptly Cancelled

Good financial management requires that unnecessary obligations be cancelled as promptly as possible so that the obligated funds can be used to meet other needs. Fiscal Service is responsible for monitoring two major categories of obligations -- accrued services payable and undelivered orders. Accrued services payable are obligations established to pay the estimated cost of services contracted for but not yet received. Typical accrued services include obligations to pay utility costs and charges under recurring maintenance contracts. Undelivered orders are obligations established to pay for supplies and certain types of services that have been ordered.

VA policy requires Fiscal Service to coordinate with A&MMS to ensure that the obligation is necessary. Each month Fiscal Service should analyze accrued services payable and undelivered orders reports to identify outstanding payables and delinquent orders. (A payable is considered to be outstanding and an order is considered to be delinquent if the obligation is more than 90 days old.) Fiscal Service should contact the VAMC service that initiated the payable to determine whether the obligation is still needed. If it is not needed, the obligation should be cancelled (MP-4, Part V, 2G.03 and 3B.03).

The monthly reviews are important because unneeded obligations can be cancelled and the funds can be reobligated to meet other needs, provided that the unneeded obligations are identified and reprogrammed before the applicable appropriation expires (that is, typically before the end of the Fiscal Year).

As of November 5, 1999, the VAMC had 1,811 obligations valued at $31.1 million. To determine if Fiscal Service reviewed obligations each month and cancelled delinquent obligations when appropriate, we reviewed a judgment sample of 20 obligations (10 accrued services payable valued at $283,696, and 10 undelivered orders valued at $1,487,307). We found that Fiscal Service needed to improve the timeliness of their action on unliquidated obligations. Four of the 10 accrued services payable (value = $40,435) and 2 of the 10 undelivered orders (value = $29,015) could have been deobligated.

The Chief of Fiscal Service acknowledged that unliquidated obligations should be reviewed each month, but he indicated that staffing resources made this difficult to accomplish every month. He agreed that Fiscal Service needed to establish controls to ensure that, at a minimum, unliquidated obligations are thoroughly reviewed every quarter.

Recommendation 7. The VAMC Director should require that Fiscal Service establishes effective controls to review unliquidated obligations and to ensure that unneeded obligations are cancelled before the end of the fiscal year so that the funds can be made available for other uses.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. As of January 2000, the Business Office established procedures to thoroughly review unliquidated obligations at least once a quarter, to investigate delinquent obligations, and to promptly cancel obligations that are no longer needed.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issue to be resolved.

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

VA Handbook 6210 provides procedures and practices for protecting Automated Information System (AIS) resources from unauthorized access, disclosure, modification, destruction, or misuse. Using this handbook and other guidelines, we performed a limited review of AIS security controls.

Internet security and physical security for the computer room were adequate. VAMC management had implemented effective policies and procedures to protect the integrity and confidentiality of data and to control and monitor access to automated systems and local area network applications. However, our review identified three areas where security could be enhanced and brought into full compliance with VA policy:

- **Password Changes.** Local Area Network (LAN) users were not required to change their passwords at least once every 6 months (VA Handbook 6210, Chapter 7, 3b (b)). Because

the LAN is a critical system for the processing of VA data, it is important that security be maintained by all the means stipulated in VA policy, including the changing of passwords at designated intervals.

- **Annual AIS Training.** The VAMC's Information Resources staff provided employees with initial AIS security training. However, they did not provide annual refresher training. All VA employees are required to receive this training to keep them aware of the vulnerabilities of computer systems and the need to protect data (VA Handbook 6210, Chapter 2, 4g (1)). Before our review, VAMC management had recognized the lack of annual training and were evaluating the resources necessary for conducting this training.

- **Contingency Plan.** VAMCs are required to develop and implement information system contingency and recovery plans. The plans should be designed to reduce the impact of disruptions in services, to provide critical interim processing support, and to resume normal operations as soon as possible. We concluded that the VAMC's contingency plan effectively addressed most issues. However, the plan did not include a designated alternative processing facility that could provide backup to AIS services in the event that the primary facilities are severely damaged or could not be accessed (VA Handbook 6210, Chapter 1, Section 2). During the review, management agreed to identify an alternative processing site. When this is completed, the designated site should be added to the contingency plan.

Recommendation 8. The VAMC Director should ensure that: (a) controls are established to ensure that LAN users change their passwords at least every 6 months; (b) annual refresher AIS training is provided to all employees; and (c) an alternative processing site is designated in the AIS contingency plan.

Medical Center Director Comments. The VAMC Director concurred with the recommendation. However, for Recommendation 8(a) the Director indicated that changing passwords every 6 months for the VAMC's high number of employees would be excessive and would be detrimental to sound password control and AIS security. VA's Office of Information and Technology informed the VAMC that a software solution to this problem is currently being piloted. Once a national software solution is released, the VAMC will implement the software.

As of March 2000, Recommendations 8(b) and 8(c) had been implemented. AIS training will be conducted every year and will be documented. An alternate processing facility has been determined and added to the VAMC's AIS security plan.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issues to be resolved.

Fraud and Integrity Awareness Briefings

As part of the CAP review, Office of Investigations agents conducted two 90-minute Fraud and Integrity Awareness briefings, which included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. About 100 VAMC employees attended the briefings. The information presented in the briefings is summarized below.

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

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

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

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

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

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

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

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

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

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

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center Denver, Colorado

Project Number: 2000-00473-R8-0196

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
6(a) and (b)	Better use of funds through stronger collection efforts on delinquent accounts receivable ($32,456 from local providers and $20,068 from the Air National Guard).	$52,524	

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: April 21, 2000

From: Medical Center Director (554/00/00A), VAMC Denver

Subj: Draft Report: Combined Assessment Program Review, VA Medical Center, Denver CO (Project No. 2000-0047-R8-0196)

To: Assistant Inspector General for Auditing (52)

1. Thank you for the opportunity to comment on the subject Draft Report of our recent Combined Assessment Program review.

2. The following comments are provided in reference to the recommendations included in the report:

   Executive Summary: I am in concurrence with the findings, and with minor Exception, the recommendations resulting from the Combined Assessment Program Review of the Denver VA Medical Center. The Office of Assistant Inspector General conducted the review in a highly efficient and effective manner that included close coordination with the Medical Center. This allowed for a comprehensive review of numerous important activities with minimal disruption to our operations. We have found the findings and recommendations reasonable and useful in our efforts to improve our systems for the delivery of safe, quality, and fiscally responsible health care.

   Recommendation 1: Concur. The issues cited will be shared with the appropriate program officials for corrective actions where warranted. Written reports will be required indicating assessment of the cited issues and corrective actions taken.

   Recommendation 2: Concur. As of January 3, 2000, we have modified our contracting procedures to require that contracting officers obtain the necessary cost data and complete the required PNMs. We are now monitoring performance on all contracts and, for future contracts, the contracting officer will ensure that COTRs have established effective monitoring procedures.

   Recommendation 3: Concur. On January 10, 2000, the purchase card coordinator's duties were transferred to the Administrative Officer in Acquisition & Materiel Management Service.

   Recommendation 4: Concur. As of February 1, 2000, Pharmacy Service began a project to reduce inventory levels. To begin, we will review and reduce as needed, the levels of the 20 high cost drugs (highest per unit cost) that have had fluctuations in usage. If we can successfully manage our requirements for these drugs, we will continue to reduce stock levels and try to achieve the 10-day goal for most drugs. We have begun scheduling education for all staff involved in inventory transactions. This education consists of reports available through prime vendor to help manage

inventory levels. When the drug accountability software is operational, we will implement additional inventory management practices. The initial education was completed as of March 1, 2000. By July 17, 2000 A&MMS will complete implementation of the case cart system and will bring the SPD GIP data up to date.

Recommendation 5: Concur with ensuring that excess, outdated, and unused controlled substances are included in monthly inspections. As of February 1, 2000, all monthly inspections include the review of all controlled substances set-aside for destruction.

Recommendation 6: Concur. As of January 1, 2000, the Business Office has established procedures to aggressively pursue receivables and to review delinquent receivables every 90 days. An accounting technician will call on all receivables that are open longer than 90 days and request payment. As of February 2, 2000, we have requested guidance from Headquarters regarding additional measures to be taken to collect monies owed by the Air National Guard (ANG), including a request for a billing contact within DOD at a higher level than the contact at Buckley ANG.

Recommendation 7: Concur. As of January 31, 2000, the Business Office has established procedures to thoroughly review unliquidated obligations at least once a quarter, to investigate delinquent obligations, and to promptly cancel obligations that are no longer needed.

Recommendation 8: Concur with Recommendation 8.a., however, changing passwords every six months for our number of employees would be excessive. The high volume of changing passwords would be detrimental to sound password control and AIS security. Upon inquiry to the VA Headquarters Office of Information, we have been informed that a software is released, the Denver VAMC will implement the software.

Concur with Recommendations 8.b. and 8.c. As of March 1, 2000, these two recommendations have been implemented. The AIS training will be conducted every year and will be documented. We have determined an alternate processing facility and have added it to our AIS security plan.

Page 3

To: Assistant Inspector General for Auditing (52)

3. An electronic copy of this response has been included on the enclosed disc. Also, we have forwarded an e-mail version to your office. If you have any questions pertaining to these comments, please call Joe Dean, Special Assistant/Director at (303) 393-5175.

(Original signed by:)
E. Thorsland, Jr.

Enclosure

Final Report Distribution

VA Distribution

Secretary (00)
Acting 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 Congressional Operations (60)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (90)
Director, Office of Management and Financial Reports Service (047GB2)
Chief Network Officer (10N)
VHA Chief Information Officer (19)
Veterans Integrated Service Network Director (10N19)
Director, VA Medical Center Denver, Colorado (554/00)

Non-VA Distribution

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

Honorable Wayne Allard, United States Senate
Honorable Ben Nighthorse Campbell, United States Senate
Honorable Diana DeGette, House of Representatives
Honorable Mark Udall, House of Representatives
Honorable Bob Schaffer, House of Representatives
Honorable Thomas G. Tancredo, House of Representatives