



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Medical & Regional Office Center Wilmington, Delaware

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are 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 and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

	PAGE
EXECUTIVE SUMMARY	i
INTRODUCTION	1
RESULTS AND RECOMMENDATIONS.....	4
Patient Care and Performance Management.....	4
Medical and Financial and Administrative Management	8
Regional Office Program Operations	18
Fraud Prevention.....	26
 APPENDIX	
A. Report Distribution	28

Combined Assessment Program Review VA Medical and Regional Office Center Wilmington, DE

EXECUTIVE SUMMARY

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical and Regional Office Center (VAM&ROC) Wilmington, DE during the weeks of January 8 and January 15, 2001. The purpose of the review was to evaluate patient care, quality management (QM), financial and administrative management controls, benefits delivery, and claims management. During the review, we also provided fraud and integrity awareness training to VAM&ROC employees.

The medical center is a 58-bed acute care and 60-bed transitional care facility, providing a full range of services in medicine, surgery, neurology, and geriatrics. The medical center's Fiscal Year (FY) 2000 budget was approximately \$50 million and the staffing level was 523 full-time equivalent employees (FTEE). In FY 2000, employees treated 1,948 inpatients and reported 130,732 outpatient visits.

The regional office provides compensation and pension and vocational rehabilitation and employment services to veterans, their dependents, and survivors residing in Delaware, southern New Jersey, southeastern Pennsylvania, and the eastern shore of Maryland. During FY 2000, the regional office expended approximately \$1.35 million in general operating expenses with 24.4 FTEE.

Patient Care Administration and Quality Management. Medical center managers demonstrated a strong commitment to QM and performance improvement. The medical center had a comprehensive QM program, called performance management (PM), that effectively coordinated patient care activities and provided strong oversight. We identified opportunities to further improve patient care services and PM.

Medical Center Financial and Administrative Management. Financial and administrative activities were generally operating satisfactorily and controls were generally effective. We identified opportunities for improvement and recommended that the VAM&ROC Director: (a) strengthen controls over Current Procedural Terminology coding and health insurance billing; (b) improve controls over medical supply inventories; and (c) strengthen information technology security. To further improve operations, we also suggested that the VAM&ROC Director: (a) strengthen controlled substances inspections; (b) improve controls over means testing; and (c) strengthen controls over collecting delinquent debts.

Regional Office Program Operations. Regional office management established a positive internal control environment. The administrative activities reviewed were generally operating satisfactorily and management controls over the benefits delivery

process were generally effective. We identified opportunities for improvement and recommended that the VAM&ROC Director strengthen controls over: (a) compensation and pension claims processing; and (b) vocational rehabilitation and employment claims processing. To further improve operations, we also suggested that the VAM&ROC Director strengthen controls over: (a) benefit adjustments for veterans receiving long-term care at VA expense; (b) the completion of field examinations and accountings; and (c) physical security of Benefits Delivery Network workstations.

Fraud Prevention. VAM&ROC managers fully support fraud prevention efforts. In the past, managers referred numerous issues to the OIG's Office of Investigations. As part of our review, we provided fraud and integrity awareness briefings to 257 VAM&ROC employees.

VA Medical and Regional Office Center Director's Comments. The Director concurred with the CAP review recommendations and provided acceptable plans to take corrective action. The Director also clarified some of the issues in our suggestions. For example, he provided statistical data showing Pharmacy waiting times have been decreasing and are within VHA's 30-minute standard. However, we suggest further review to determine why patient complaints regarding pharmacy waiting times are increasing.

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

Introduction

V A Medical and Regional Office Center Wilmington, DE

Background. The VA Medical and Regional Office Center (VAM&ROC) Wilmington is a co-located facility on the medical center grounds in Wilmington, DE. The medical center is a tertiary care facility providing a full continuum of medical, surgical, neurological, and nursing home care. The medical center is one of ten facilities comprising the Stars and Stripes Healthcare Network in Veterans Integrated Service Network (VISN) 4.

The regional office provides compensation and pension (C&P) and vocational rehabilitation and employment (VR&E) services to veterans, their dependents, and survivors. Education, insurance, and loan guaranty services are provided by VA Regional Offices (VAROs) in Buffalo, NY, Philadelphia, PA, and Cleveland, OH. The regional office is one of seven in the Veterans Benefits Administration's (VBA's) Service Delivery Network (SDN) 2.

As a component of VISN 4, the medical center reorganized by patient care centers, which are similar to care/service lines. The patient care centers include Medical Care, Surgical Care, Patient Support Center, Acute and Extended Care, Outpatient Center, Facilities Center, and Resources Center.

The medical center opened community-based outpatient clinics (CBOCs) to provide primary care and mental health services in high veteran population areas. Currently, the medical center has three CBOCs located in Vineland and Ventnor, NJ, and Millsboro, DE, serving veterans in DE, southern NJ, and northeastern MD.

Affiliations and Programs. The medical center is academically affiliated with the Thomas Jefferson University Medical School, the University of Maryland Medical College, the University of Delaware College of Nursing, and the Pennsylvania College of Optometry.

Resources. The medical center's Fiscal Year (FY) 2000 budget was approximately \$50 million. Current staffing totals 523 full-time equivalent employees (FTEE). The facility has 58 acute care beds plus 60 transitional care beds authorized as of the first quarter of FY 2000. During FY 2000, the regional office expended approximately \$1.35 million in general operating expenses with 24.4 FTEE.

Workload. Medical center clinicians treated 1,948 inpatients and reported 130,732 outpatient visits in FY 2000. The regional office's C&P workload ranked 56th among all regional offices. The regional office serves a veteran population of approximately 75,000. During FY 2000, a total of about \$44 million in C&P benefits were paid to 9,000 beneficiaries.

Objectives and Scope

The purpose of the CAP review was to evaluate selected medical center clinical, financial, and administrative operations, selected regional office administrative activities and benefits delivery processes, and to provide fraud and integrity awareness briefings to VAM&ROC employees.

Patient Care and Performance Management Review. We reviewed selected clinical activities to evaluate the effectiveness of the facility's performance and patient care management practices. Performance management (PM) consists of 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 safety and treatment. PM includes risk management, quality management (QM), and patient safety. 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 PM program and patient care management, we inspected patient care areas, reviewed pertinent clinical and PM records, and interviewed managers, employees, and patients. We also used questionnaires and interviews to survey employees' and patients' opinions and perceptions about the quality of care and other matters such as waiting times and satisfaction with care received. We reviewed the following programs and patient care areas:

Acute Care Medicine
Ambulatory Care
Clinic Appointment Timeliness
Credentialing and Privileging
Narcotic Usage
Performance Management
Physical Plant Cleanliness

Geriatrics and Extended Care
Mental Health
Clinician Staffing
Pain Management
Medical Billing
Patient Safety

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

Unliquidated Obligations	Controlled Substances Inspections
Employee Debt Collection Activities	Agent Cashier
Contract Beneficiary Travel	Supply Inventory Management
Denied Medical Care Collection Fund (MCCF) Claims	Automated Information Systems Security
MCCF Billing and Collection Activities	Purchase Card Program
Clinical Services Contracts	Means Test Implementation
Contract Community Nursing Home Rates	Part-time Physician Timekeeping

Regional Office Program Operations Review. We reviewed selected administrative activities and the benefits delivery process with the objective of evaluating the effectiveness of management controls. In performing the review, we interviewed managers and employees, and reviewed pertinent administrative, financial, and claims records. The review covered the following administrative activities, controls, and benefits delivery areas:

Agent Cashier	C&P Medical Examinations
Fiduciary and Field Examination Section Activities	Timeliness and Accuracy of C&P Claims Processing
Vocational Rehabilitation and Employment Program	Retroactive Payment Controls
C&P Benefit Overpayment Controls	Benefit Adjustments
Returned Mail Processing Controls	Purchase Card Program
Board of Veterans Appeals Remands	C&P Record Security
	Decision Review Officer

Fraud Prevention. VAM&ROC managers are supportive of fraud prevention. In the past, several issues had been referred to the OIG's Office of Investigations. We provided five fraud and integrity awareness briefings to 257 V AM&ROC employees. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review covered operations for FY 1999 and FY 2000. The review was done in accordance with the OIG standard operating procedures for CAP reviews.

RESULTS AND RECOMMENDATIONS

Patient Care and Performance Management

Indicators of Reliable Monitors and Good Healthcare Programs

Performance management monitors – Medical center managers emphasized to employees the need to improve timeliness and access in primary care for improved patient outcomes. The Director conducted open forums, met with the local care/service line managers, and made unscheduled rounds to identify and discuss quality of care issues with employees.

The medical center had a comprehensive performance management (PM) program that provided effective oversight of the quality of care provided at the medical center using national and local performance measures, risk management, utilization management, and peer reviews. PM employee's trended and tracked results of patient safety and performance improvement monitors and internal and external reviews, and recommended corrective actions when appropriate. Peer review data was provided to service chiefs who used this information to make recommendations about reprivileging.

Managing outpatient care – Behavioral health workload reports showed that managers were increasingly emphasizing outpatient care. Patients in need of acute psychiatric services were referred to nearby VA medical centers for their care. For the most part, patients expressed a high level of satisfaction with their outpatient treatment.

Controlled substances for psychiatric patients – Managers ensured complete documentation for administering controlled substances to psychiatric patients for prolonged periods. We reviewed eight cases in which patients were treated by attending staff psychiatrists who issued prescriptions for Percocet® (oxycodone/acetaminophen) and Tylenol III® (codeine/acetaminophen). We found that the patients' needs and therapeutic goals related to the use of the controlled substances were consistently addressed in treatment planning records, and that clinicians utilized alternative modes of pain management.

Patient and employee satisfaction – Patients and employees whom we surveyed were generally satisfied with the care provided at the facility. Fifteen (88 percent) of the 17 patients responding to our survey rated the care received as good, very good, or excellent. Of the 104 employees who responded to our survey, 94 (90 percent) rated the quality of the care provided as good, very good, or excellent. Eighty-four percent (87 of 104) of the employees would recommend treatment at the facility to family members or friends. Of the 115 employee respondents, 102 (89 percent) said they gained personal satisfaction from their work. Employees generally felt safe coming to and working at the facility and believed coordinated care was provided to patients

Indicators Suggesting Need for Management Oversight and Evaluation

Employee concerns – We found that 56 (67 percent) of the 84 employees responding to our survey said they did not have sufficient staff in their work areas to provide care to all their patients. Additionally, 25 (39 percent) of 64 employee respondents said they did not feel comfortable reporting errors that involved other employees and 21 (36 percent) of 59 respondents did not feel constructive action was taken when an error was reported. We discussed these survey results with managers during the exit conference to encourage further study in these areas.

Director's Comments: The Director viewed this as an opportunity for further improvement. He told us that the Risk Manager and QM assistant have been working with staff via the Bar Code Medication Administration (BCMA) team to encourage reporting of not only errors but of near misses. Staff from all inpatient units participated on this team. Reporting is now sent to the BCMA team for analysis. Reporting has increased in the past 3 months due to improved communication with staff and providing feedback on issues. Also, staff members are now participating on root-cause analysis teams and receive information first hand on follow-up and results of actions. These actions had already been started prior to the OIG visit but had not yet become part of the culture of the organization. Another way that employees are supplied with information of corrective actions is through minutes that are forwarded electronically to all employees.

Office of Inspector General's Comments: The Director's comments and actions address our concerns.

Pain management compliance – We sampled 15 physician and nurse education records and found that 7 of the 15 records contained evidence of pain management training. We also reviewed 10 medical records of discharged patients who had pain scores greater than 4 on a 10-point scale and found only 4 contained evidence of patient or family education and pain management instructions in the discharge plans. Of the 16 nurses and 2 physicians interviewed, 5 of the nurses did not know if the facility's new employee orientation or employee annual reviews addressed pain management education, and had not received information concerning results of PM pain management studies. Eleven of the 16 nurses and both physicians felt that patients would benefit from strong pain management programs and pain treatment alternatives. Managers were aware of these weaknesses and were conducting medical record reviews to assess clinicians' adherence to pain management guidelines. They also were surveying clinical employees to assess pain management educational needs.

Director's Comments: The Director viewed this as an opportunity for further improvement. He told us that since the beginning of the fiscal year, attendance at 114 classes relating to pain issues had been recorded into the Training Education Management Program (TEMPO) system. The Pain Management Group has been working to increase opportunities for training on pain management for staff. An annual Pain Awareness Day was started in 2000. This provides training to both staff and patients and their families. All clinical staff members have pain management as part of

their competency assessments. This latter measure has been in place since 1999. New employee orientation offers a class on pain management given by the Pain Management Coordinator and clinical managers have included a class on pain management in annual training for clinical staff. The medical center has a templated nursing discharge note that includes education and pain management instructions, but documentation by staff needs improvement. We also have monitors to collect data on how pain is addressed in the Emergency Room and at each outpatient visit. During FY00, PM employees reviewed 781 records for pain screening. On average, 20% of patients reported that they had pain. The medical center is establishing monitors to gather data on how pain is addressed on admission to hospital and on discharge. This will also capture data on pain education to veterans and their families. This information will be tracked by the Pain Management Group and reported in the Medical Records Committee minutes.

Office of Inspector General's Comments: The Director's comments and actions address our concerns.

Waiting times – Patients complained of long waiting times to obtain prescriptions from Pharmacy Service. We reviewed the Patient Advocate Summary Report for FY 2000. The report showed an increase in the number of patient complaints related to excessive waiting times for prescriptions at the pharmacy (2 hours or longer) and timeliness of mail-out prescriptions. Pharmacy managers attributed the long waiting times to staffing shortages and increased workload.

Director's Comments: The Director said that by the time of the January 2001 OIG visit, the window wait time had already started to decrease. He said managers have been tracking Pharmacy window waiting times for the past few years, and there had been a significant decrease in waiting times over the past 2 fiscal years. This coincides with the policy change to fill only new prescriptions locally. All refills are sent to the Consolidated Mail Outpatient Pharmacy. He told us the facility is now well within the 30-minute standard and is competitive with the private sector benchmark of 20 minutes.

Office of Inspector General's Comments: The Director's data demonstrates that Pharmacy waiting times have been decreasing over the past 2 years and are within VHA's 30-minute standard. However, we suggest that further review is needed to determine why the volume of patient complaints concerning long waiting times to obtain prescriptions from Pharmacy Service are increasing, and take appropriate actions.

Clinic appointments – Managers needed to reduce the time patients waited to obtain appointments for some clinics. The Veterans Health Administration (VHA) established a waiting time performance goal of 45 days or less for six defined clinics by the end of FY 2000. As of October 1, 2000, four of the six defined clinics far exceeded the 45-day goal – Primary Care (79.6 days), Eye Care (133.9 days), Audiology (81.2 days), and Urology (97.7 days). Managers told us that performance teams had successfully decreased Cardiology and Orthopedic Clinic waiting times and the teams are being used to reduce waiting times in these four clinics.

Director's Comments: The Director told us that the facility is participating in the VISN initiative with the Institute for Healthcare Improvement (IHI). IHI Teams have been addressing waiting times in Primary Care, Eye, and Audiology. Current figures are: Primary Care – 7 days; Audiology – 46 days; and Eye – 0 days. An IHI team has been launched to address Urology Clinic's wait time and similar success is expected.

Office of Inspector General's Comments: The Director's comments and actions address our concerns.

Medical Center Financial and Administrative Management

Indicators of Reliable Financial and Management Practices

VAM&ROC Wilmington management had established a positive internal control environment. The administrative activities reviewed were generally operating satisfactorily and management controls were generally effective.

Recommended Financial and Administrative Management Improvements

Management should ensure the accuracy of coding and billing – Bills to insurance carriers for reimbursement must contain 5-digit Current Procedural Terminology (CPT) codes for reporting services performed by physicians and other approved providers, such as nurse practitioners, clinical pharmacists, and dieticians. CPT codes identify the procedures or services performed by the providers and are used in computing the charges. Proper coding depends upon accurate documentation in the patient's medical record.

We selected a judgment sample of 36 bills to insurance carriers for outpatient care provided to patients during September and October 2000. We reviewed coding and billing with the Chief Financial Officer, the Compliance Officer, the Coding Supervisor, and the Medical Care Collection Fund (MCCF) Biller. Eleven cases (31 percent) in our sample were incorrectly coded or billed. The following inaccuracies were noted:

- In two cases, visits with a clinical social worker and psychiatrist were coded at a lower level (under-coded) than the services provided. Billings for these services initially totaled \$21.82 and were increased to \$177.86. The error has been corrected.
- In one case, a visit was coded at a higher level (up-coded) than the service provided. A chemotherapy infusion code was assigned to a physician visit and billed at \$113.72. The physician visit should have been assigned an evaluation and management code and billed at \$43.63. The error has been corrected. The chemotherapy infusion was performed by a nurse and billed appropriately as an institutional charge of \$1,349.02.
- In three cases, there was no provider documentation in the patients' records for services coded and billed for a laryngoscopy procedure (\$333.73), a psychiatric visit (\$77.44), and an optometry visit (\$43.63). These bills have been cancelled.
- In one case, a \$37.08 bill for prosthetics was incorrectly canceled, and the reason for cancellation was provided as "Per Coding Non-Billable Services." The service has been re-billed.
- In two cases, care provided was not billable. A required annual employee examination billed in error for \$162.08 and a visit by a patient wishing to obtain medications prescribed by a non-VA physician billed in error for \$49.62. The patient was not examined nor did he receive treatment. These bills have been canceled.

- In two cases, pathologists' examinations of biopsy specimens were not billed. The errors have been corrected and each case has been billed for \$202.96.

We also reviewed evaluation and management codes for 40 outpatient visits (10 non-billable and 30 billable visits) that occurred during the second quarter of FY 2000. The following inaccuracies were noted:

- Nine (23 percent) of the 40 cases were incorrectly coded (2 were under-coded and 7 were over-coded).
- Eight (27 percent) of the 30 billed cases were billed in error (6 were over-billed a total of \$297.09 and 2 were under-billed a total of \$110.82).

Managers told us that coders and MCCF staff received additional training since the time of the sample cases of this review and they believe this has strengthened their coding compliance. However, 23 (55 percent) survey responses we received from 42 employees (including 8 physicians, 20 nurses, and 14 allied health providers) indicated they had not attended education and training on documentation, coding, and billing, and were not aware of any such training. Therefore, training and education were needed to improve billing and coding compliance.

These problems occurred because trained specialists did not properly review and code all outpatient visits. The codes appearing on the bills were selected by service providers at the time of the encounters, and were subsequently billed without review. Codes entered by providers frequently reflected workload rather than billable services. Managers explained that there were only three coders at the time of our review and they had not been successful in recruiting additional coders. They had recently initiated a 100-percent review of insured outpatient encounters which should result in improved coding for billing purposes.

Recommendation 1. The VAM&ROC Director should:

- Enhance the accuracy of CPT coding and improve the integrity of the billing process.
- Require that providers document patient care accurately and promptly.
- Continue recruiting additional coders.
- Provide additional training and education.

Director's Comments:

- a. Concur. As we are still in the early years of reasonable charges, there is always room for improving the CPT coding and billing process. Our process now includes a 100% review of billable episodes by coding specialists prior to billing. The billing staff and coding staff have developed a strong collaborative relationship to ensure the production of clean claims. The billing and insurance staff are working with insurance companies to ensure our claims meet the third-party insurance requirements. MCCR (billing, insurance, A/R), coding staff, and UR staff participate in weekly sessions focused on accurate coding and process improvement.
- b. Concur. The new process includes feedbacks to providers on documentation via a vis CPT codes, especially evaluation and management codes. The Utilization Review Nurse, Chief of HIMS, MCCR Coordinator, and Compliance attend monthly provider staff meetings to share aggregate results and discuss provider documentation and attending notes. Providers are encouraged to dictate outpatient progress notes to improve documentation of care. Providers are directed to participate in national coding satellites and VISN-level training. Before the end of the year, one-on-one training is planned with a Medicare auditor to address specific provider questions.
- c. Concur. Our efforts to recruit coding staff have been unsuccessful. We are using a very highly rated contract coding company, Langley Provider Group, Inc., to provide assistance in keeping coding review of billable episodes current. We are continuing to work with a community billing/coding school to find future coding candidates for permanent positions.
- d. Concur. Educational efforts are ongoing with weekly meetings as described above, provider meetings, and participation in VISN and Central Office training episodes on coding, Medicare, and MCCR processes. In addition, we have scheduled a Medicare auditor to provide provider education in small groups or one-on-one. And always, we have included training about reasonable charges, service connection, and co-pay for all new employees in orientation and all employees through staff meetings and written employee newsletters.

Two mandatory training sessions on E&M coding and documentation were offered for providers in 1998 and 1999. We have documented that all providers attended the training. With 8 physicians indicating they did not attend, we obviously need to conduct additional training that they will remember.

Office of Inspector General's Comments: The Director's actions and planned actions are acceptable and we consider the issue resolved.

Managers should improve control over medical supply inventories – Employees did not effectively use the Generic Inventory Package (GIP), VA's automated inventory management system, to manage and control the Supply Processing and Distribution (SPD) and Supply Fund warehouse inventories. VHA guidelines require the use of GIP to manage and control supply inventories. However, GIP data must be accurate for the program's automated management features to identify excesses and shortages. Inventories generally should not exceed a 30-day maximum supply.

VAM&ROC Wilmington had two primary inventories: a SPD primary inventory located in the main building, and a warehouse primary inventory located in a separate building on campus. The warehouse primary inventory had been purchased using the Supply Fund and was being phased out. During the 1-year period from December 1, 1999 through November 30, 2000, the medical center spent approximately \$1,067,543 for SPD medical supplies.

Excess Stock – GIP records for the combined SPD and warehouse inventories indicated that 95 percent of the medical supply items on hand exceeded the 30-day stock level. The value of the excess stock was \$344,737.

- The SPD inventory had 475 line items valued at \$355,590. Based on the Days of Stock on Hand Report, 454 (96 percent) of these line items valued at \$335,869 exceeded a 30-day supply.
- The warehouse inventory had 29 line items on hand valued at \$11,294. The reported inventory exceeded a 30-day supply in 27 (93 percent) of the line items valued at \$8,868.

Inventory Errors – We physically inventoried a judgment sample of 20 line items, 16 from SPD and 4 from the warehouse. All four warehouse sample items were accurate. However, in all 16 SPD items, actual stock on hand was lower than the GIP inventory balance. Managers stated that the location of SPD was changed 2 years ago, and staff was lost through attrition and not replaced. As a result, the recording of stock issues and receipts was sporadic and records were inaccurate. An accurate estimate of the value of excess stock on hand cannot be determined until wall-to-wall inventories are conducted.

Recommendation 2. The VAM&ROC Director needs to effectively implement GIP, and ensure that:

- a. A wall-to-wall inventory is completed at the SPD location and the results are reconciled with the automated records.
- b. SPD and the warehouse stock inventories are reduced to 30-day supply levels.
- c. Emphasis is placed on timely and accurate data entry for inventory receipts and withdrawals.

Director's Comments:

- a. Concur. The warehouse primary inventory point has been phased out and replaced with a new primary inventory point called Storage and Distribution (located in the warehouse). On June 8, 2001, a complete wall-to-wall inventory was done on this new primary.
- b. Concur. Levels were put in place to maintain a 30-day supply. On July 10, 2001 and August 7, 2001, we will do a 30 and 60-day follow up to check items for activity and make additional, deletions, and level adjustments, if necessary, to maintain the 30-day supply.
- c. Concur. A wall-to-wall inventory is planned for Central Services in August of 2001. The GIP will be updated to reflect the correct quantities on the shelf, to make additions and deletions, and set levels to maintain a 30-day or less supply. A 30 to 60-day follow up will be set up to check levels.

Training has been provided to SPD staff on proper procedures for using GIP to manage inventory. Full implementation of GIP will be completed in September 2001.

Office of Inspector General's Comments: The Director's actions and planned actions are acceptable and we consider the issue resolved.

Automated information system (AIS) security should be improved – VA, VHA, and the Office of Management and Budget provide policy, procedures, and practices for protecting sensitive automated resources from unauthorized access, disclosure, modification, destruction, or misuse.

We found appropriate controls in place over security awareness training, reporting of security breaches, and contingency planning. However, we noted several information technology areas in which security could be enhanced:

- VA policy requires that user passwords be at least eight characters in length and contain a combination of letters, numbers, and special characters that are not alphanumeric. Passwords are to be changed every 90 days. We found that the VAM&ROC had not fully implemented this policy. Medical center managers, while requiring passwords be changed every 90 days, had not required passwords to be at least eight characters in length, nor had they required the use of numbers and special characters. In a highly interconnected environment such as the VAM&ROC's, it is imperative that strong password controls be implemented to reduce the risk of unauthorized access to VA systems. The regional office had fully implemented current password policy.
- VA policy requires that all VHA and VBA facilities establish and implement a risk analysis process for each identified AIS resource. The risk analysis process should ensure that the balance of risks, vulnerabilities, and threats achieve a level of risk that is acceptable based on the sensitivity or criticality of the individual systems. We found that medical center managers had completed seven individual system risk

analyses but had not completed an overall facility risk analysis that also included the regional office's systems. At the time of our review, a separate risk analysis process did not exist for the regional office.

- Access to sensitive VA resources should be limited to only those individuals with a need for the access to perform their duties. VA policy states that all user accesses and privileges must be reviewed at least every 90 days to determine whether users have a continued need for access, and if so, whether they are assigned the appropriate level of access. We obtained a November 2000 list of the VAM&ROC's Veterans Health Information Systems and Technology Architecture (VISTA) accounts. This list contained 796 VISTA user accounts and included unneeded test accounts and accounts for users who had terminated VAM&ROC employment. We requested that the Information Security Officer (ISO) review the list to determine those users whose access was no longer needed. Based on our request, the ISO terminated access for approximately 375 VISTA users. Our review revealed that VISTA user privileges were not being reviewed at least every 90 days and termination dates were not entered in a timely manner.
- VHA policy requires that each facility Director assign an ISO to establish, maintain, and enforce a comprehensive AIS security program. VHA policy further requires that the ISO should be a full-time position in larger and consolidated facilities and, at a minimum, the primary responsibility for ISOs in smaller facilities. We found that AIS security was not the primary responsibility of the VAM&ROC's ISO. The ISO informed us she spent only about 10 hours a week on ISO duties. Furthermore, she was not dedicating any time to the AIS security of the regional office. Appointing an ISO whose primary responsibility is the ISO function would enhance security by allowing that individual to focus on ISO responsibilities as defined by VHA policy.

Recommendation 3. The VAM&ROC Director should improve AIS security by ensuring that:

- a. The facility complies with VA policy regarding user passwords.
- b. A facility-wide risk analysis is completed, to include the regional office's AIS resources.
- c. VISTA access is restricted by improved monitoring of employee access and assuring the accurate entry of employee termination dates into VISTA.
- d. ISO duties are the primary responsibility for the facility's ISO and that these duties include coverage of the regional office's information security.

Director's Comments:

- a. Concur. All required protocols for utilizing STRONG passwords are in place at the Medical Center. The NT network has been reconfigured in conjunction with the VISN and national VHA instructions. VISTA has been patched to require the use of STRONG access and verify codes. This action was completed as of May 31, 2001.

- b. Concur. The Medical Center risk assessment was completed in September 2000. A VBA assessment will be completed by June 2001 utilizing the same information as on the Medical Center Risk Assessment. This will then be incorporated into the assessment for the entire VAM&ROC.
- c. Concur. The current security officer is verifying the need for access on a monthly basis. All users that have not accessed the system within 90 days and/or who have no need for access have access terminated. Additionally, Human Resources notifies IRM of those individuals that will leave or have left the station. IRM uses this notification as a cross check to make sure all departing employees' access is terminated.
- d. Concur. We are presently interviewing candidates for a part time (51%) Information Security Officer position for the VAM&ROC. We expect the individual to be in place by mid to late July 2001.

Office of Inspector General's Comments: The Director's actions and planned actions are acceptable and we consider the issue resolved.

Indicators Suggesting the Need for Management Review and Evaluation

During our review, we noted several administrative issues that warranted management attention. We made suggestions for improvements in the following areas.

Managers should ensure that controlled substances inspections are properly conducted and unusable drugs are disposed of quarterly – VHA Handbook 1108.2, "Inspections of Controlled Substances," dated July 23, 1997, requires that VA medical facilities conduct monthly unannounced inspections of all Schedule II-V controlled substances to ensure proper accounting of controlled substances. A sample of dispensing entries should be compared to patient records to verify that amounts removed from the wards and clinics were supported by doctors' orders and drug administration records. A program for orientation and training of inspecting officials should be established and followed. Each medical facility must maintain documentation on all orientation and training provided. Written records of all inspections must be maintained and inspection results should be trended to identify potential problem areas for improvement. All excess, outdated, unusable, or returned controlled substances must be stored in sealed containers, in the locked area of the pharmacy while awaiting disposal. These controlled substances must be inventoried monthly and should be disposed of at least quarterly.

To assess the VAM&ROC's controlled substance inspection program we reviewed records of the inspections conducted during the 12-month period from November 1999 through October 2000. We identified the following weaknesses:

- Inspectors did not verify a sample of dispensing entries in all clinics and ward areas to ensure that amounts dispensed were supported by medication orders and drug administration records.

- There was no documentation of formal training provided to inspectors.
- Inspection results were not trended to identify potential problem areas for improvement.
- All excess, outdated, unusable, and returned controlled substances were not stored in sealed containers, were not inventoried monthly, and were not disposed of at least quarterly. In fact, disposal was conducted only once (November 2) during calendar year 2000.
- During the 1-year period reviewed, inspectors reported 11 Green Sheets (VA Form 10-2638, "Controlled Substance Administration Record") missing. Resolution of two missing Green Sheets was inefficient, requiring 9 months. Although all sheets were accounted for by the end of October 2000, delays in accountability resulted in inspection inefficiencies.

Pharmacy areas met physical security requirements. Controlled substances were stored and dispensed in locked areas. The VAM&ROC had installed electronic access control systems in the pharmacies to monitor access to controlled substances.

We concluded that management needed to ensure that inspections are performed in the manner prescribed in VHA Handbook 1108.2.

Directors Comments:

- **Sample patient records:** The Risk Manager, who coordinates the Narcotic Inspection program, has incorporated record sampling into the policy and reeducated inspectors on how to sample patient records to verify amounts.
- **Training Documentation:** Though the Risk Manager had been providing training to all inspectors this was not documented in a formal way. This documentation is being done in TEMPO, the staff education software.
- **Trending of results:** An inspection discrepancies report is provided to the Pharmacy and Therapeutics Committee; however, though inspections are held on a monthly basis, results were not shared with the committee consistently. The Risk Manager is now providing this information to the committee on a monthly basis.
- **Outdated Controlled Substances:** We have updated the monthly Narcotic Inspections report to include a place for the inspector to document the date of last destruction performed by the Pharmacy. Destruction is now taking place on a quarterly basis. Additionally, on a monthly basis the inspectors obtain a copy of the Destruction Holding File Report and verify it against the items awaiting destruction.
- **Green Sheets:** This is an opportunity for improvement. The issue of missing green sheets has been partially resolved by the use of automatic controlled substance dispensers. This eliminates the need for green sheets as all tracking is done electronically. Additional units are being purchased for the areas that do not currently have them. In the meantime, a coordinated effort by the pharmacist in charge of controlled substances and the Risk Manager has been instituted. They

have developed an e-mail system for tracking until the green sheets have been resolved. This has resulted in no missing green sheets since December 2000.

Office of Inspector General's Comment: The Director's comments and actions address our concerns.

Means testing procedures needed improvement – As part of MCCF requirements, co-payments are collected from certain veterans to offset costs of treatments provided for non-service connected (NSC) conditions. Patients with income below certain thresholds are exempted from these co-payments. To qualify for exemptions, each year veterans who receive care for NSC conditions must provide VHA with family income (means test) and health insurance information. By signing means test disclosures, veterans attest to the accuracy of the income information provided and certify receipt of a copy of the Privacy Act Statement. VHA facilities are required to retain signed means test forms in veterans' administrative records.

Procedures for updating means testing needed to be improved. VAM&ROC managers indicated that veterans complained of having to repeatedly provide the same demographic information when updating means tests. In response, the medical center began mailing only the second page of the Application for Health Benefits (Form 10-10EZ) for updates in November 2000. However, this page solicits only financial information without requesting the insurance data located on page one of this form. As a result, means tests updating has not provided current insurance coverage data or enhanced the medical center's ability to recover costs from health insurance companies.

We suggest that the VAM&ROC Director request all means test data from patients (i.e. financial, insurance, and demographic data) when requesting annual updates.

Director's Comments: The mailing of the full 10-10EZ was implemented immediately following the CAP review. In addition, the front-end staff and clinical support clerical staff have been realigned to a Business Office. One of the goals of the Business Office is to improve the accuracy of the patient database including demographics, insurance coverage, next of kin, and employer data at each visit.

Office of Inspector General's Comment: The Director's comments and actions address our concerns.

Delinquent debts of current and former employees needed to be pursued – As of September 30, 2000, the VAM&ROC maintained 89 accounts receivable for current or former employees valued at over \$40,000. We reviewed a judgment sample of eight accounts valued at over \$23,000.

Our review disclosed weaknesses in follow-up in four of the eight employee debts. There was no recent follow-up for three accounts in the amounts of \$1,540, \$1,168, and \$2,427. The last collection attempts for the three accounts were made in June 1990, April 1997, and May 2000, respectively. One account in the amount of \$1,287 was last pursued in January 1996, and subsequently canceled with no documentation available to support the decision.

We concluded that the VAM&ROC Director should establish controls to ensure debts owed by current and former employees are promptly pursued, and those debts determined to be uncollectible are appropriately documented and canceled.

Director's Comments: A procedure (including responsibility assignments) has been developed to pursue employee debts in accordance with VA MP4 Part VIII, September 1992. Procedures have been put in place to ensure older debts are scrutinized periodically to make appropriate determinations as to when to terminate the receivable if collection follow-up is unsuccessful. All employee receivables will have been reviewed with appropriate action taken by July 31, 2001.

Office of Inspector General's Comments: The Directors comments and actions address our concerns.

Regional Office Program Operations

Management Controls Were Generally Effective

Regional office management established a positive internal control environment. The administrative activities reviewed were generally operating satisfactorily and management controls over the benefits delivery process were generally effective. Areas reviewed that required greater management attention include: C&P claims processing timeliness; review and approval of retroactive payments; C&P benefit overpayment prevention efforts; and VR&E claims processing. Additionally, we included suggestions to ensure controls over benefit adjustments for veterans receiving long-term care at VA expense are strengthened, field examinations and accountings are promptly completed, and security over Benefits Delivery Network (BDN) workstations is strengthened.

Opportunities for Improving Management Controls

C&P claims processing should be improved – Our evaluation of the regional office's Veterans Service Center (VSC) C&P claims processing identified several issues that required management attention. A discussion of these issues follows.

Timeliness of Claims Decisions – Timely processing of claims is one of a regional office's most important customer service responsibilities. The VSC is responsible for processing C&P claims. To evaluate the VSC's timeliness, we reviewed 10 original service-connected (SC) claims with 7 or less conditions selected from the VSC's Work In Process (WIPP) system.

We identified 5 of these 10 claims with avoidable processing delays. For example, the regional office received a C&P claim on June 4, 1999, and obtained the claims file from the Records Management Center on June 11, 1999, with no service medical records enclosed. The VSC should have sent the veteran a National Archives Form 13055 (Request for Information Needed to Reconstruct Medical Data) to authorize and initiate additional service medical record searches in a timely manner. However, the VSC did not do this until February 2000, causing a 190-day avoidable delay in processing the claim. This claim had been in process for 585 days.

In another instance, the regional office received a claim on December 21, 1998. The veteran filing this claim had an "Other than Honorable Discharge" from the military. Before this claim could be considered, the VSC needed to determine the character of the claimant's discharge. Development on this issue should have begun by January 1999. However, required service records were not requested until August 2000, causing a 575-day avoidable delay in processing the claim. This case had been in process for 750 days.

We concluded that management could improve C&P claims processing timeliness by avoiding unnecessary delays. In addition to the five cases with avoidable processing delays, we found two cases in which customer service could have been improved. The

first case had a favorable rating decision, but additional information from the Navy was needed before the award could be processed. Even though the award could not yet be processed, the VSC could have notified the veteran that her claim was granted. This claim had been open for 672 days. The second case involved multiple SC conditions. The VSC had the information needed to rate some of the conditions, but was waiting for the service medical records pertaining to all conditions before rating the claim. This claim had been open for 999 days.

VSC management attributed timeliness delays to a heavy workload being processed by relatively inexperienced staff. The VSC had seven Veterans Service Representatives, which included two senior adjudicators, two trainee adjudicators, two rating specialists, and one Decision Review Officer. Review of the VSC's December 29, 2000, WIPP Report revealed a total of 1,302 pending C&P claims. Three hundred and fifty-four of these (27 percent) had been pending more than 180 days. This compared to a national average of 24.6 percent of claims pending more than 180 days and a SDN 2 average of 23.4 percent.

Review and Approval of Retroactive Payments – VA Manual M21-1, Part V, Chapter 9, stipulates that all awards and disallowances generated under the Claims Data Entry or Claims Adjudication commands are subject to review and approval by both an adjudicator and an authorizer. For any awards authorizing initial, increased, or resumed benefits for a retroactive period of more than 2 years, the VSC Chief, or supervisory designee not lower than a unit chief, is required to review and approve the award by use of a "third signature."

Original or reopened awards require three signatures when one of the following conditions exists: (a) a Disability Compensation payment exceeds \$15,000; (b) a Disability or Death Pension payment exceeds \$10,000; (c) a surviving spouse's Dependency and Indemnity Compensation payment exceeds \$10,000; or (d) any other C&P payment exceeds \$2,500.

We reviewed a judgment sample of 12 retroactive payments exceeding \$15,000 to determine whether required third-party reviews and approvals had been obtained. These awards were valued at \$852,018 and were made to 10 individuals. Each award was issued between March 1999 and September 2000, and covered a retroactive period exceeding 2 years. The awards ranged from a low of \$28,219 to a high of \$159,939. Our review revealed that each of the 12 awards lacked the required third-party reviews and signature approvals. It should be noted, however, that our review of the case files revealed that evidence such as rating decisions, medical records, and award actions supported the awards.

We concluded that management needed to improve efforts to ensure that retroactive payments receive the required third-party signature approval. The third-party review is an internal control that helps ensure the award is proper and accurately computed.

C&P Overpayment Processing – C&P overpayments occur when beneficiaries receive money to which they are not entitled, generally as a result of changes in their entitlement status (e.g., death, increased income, etc.). The VSC had 125 overpayments, valued at about \$683,000, which remained outstanding as of the end of

FY 2000. To determine whether the VSC could have prevented any of the overpayments, we reviewed a judgment sample of 10 overpayments valued at \$66,164.

We found that 6 of the 10 over-payment adjustments could have been performed more timely. In four instances, if VSC employees had promptly processed beneficiary status changes, overpayments totaling \$12,649 could have been avoided. In the other two instances, while overpayments were unavoidable, collection efforts could have been initiated sooner if VSC employees had taken timely actions to process status changes. The following example illustrates a situation in which a portion of the overpayment could have been prevented had VSC employees properly processed the status change.

- On March 17, 1998, the regional office received income verification from the employer of a veteran. On May 14, 1998, the VSC sent a 60-day due process letter to the veteran notifying him that his award was to be reduced. VSC staff should have reduced the award by late July 1998, but did not adjust the award until August 25, 2000. If action had been taken promptly, 25 months worth of overpayments valued at \$9,425 could have been avoided.

We concluded that managers needed to improve overpayment prevention efforts. Preventing C&P overpayments has been a VBA-wide problem for several years, and was previously addressed by the OIG (Report No. 7R1-B01-105, Causes of C&P Overpayments, dated December 2, 1996). Stressing the importance of overpayment prevention to VSC employees should reduce overpayments of benefits.

Recommendation 4. To improve C&P claims processing, the VAM&ROC Director should ensure that VSC staff:

- a. Review incoming claims and initiate required claims development in a timely manner.
- b. Receive training and implement proper procedures for review and approval of retroactive award payments.
- c. Implement overpayment prevention practices.

Director's Comments:

- a. Concur. Since the IG's review of operations at this Regional Office, we have increased our overall Service Center Division staff by four individuals representing an increased staffing level of roughly twenty-two percent. We plan to use this additional staff (of which three are VSR positions) to conduct more thorough reviews of incoming claims and mail, and have these employees take immediate development action where warranted.
- b. Concur. We have conducted two training sessions with our Senior Authorizers in order to insure that the requirements of M21-1, Part V, Chapter 9 are met, most especially in cases where third-party signatures are required.

- c. Concur. Later this month this management staff is scheduled to attend a three-day training seminar focusing on case and inventory management and control, and WIPP applications. This renewed focus on inventory management coupled with our increased staffing resources will allow us to address more closely case management issues such as overpayment prevention and early claims development. Problems identified in this area are resolved through a two-fold process of first identifying critical and time-sensitive issues and then having the manpower to process those issues. We are now in a position to appropriately address those issues.

Office of Inspector General's Comments: The Director's actions and planned actions are acceptable and we consider the issue resolved.

VR&E claims processing should be improved – Our review of 10 VR&E Counseling, Evaluation, Rehabilitation (CER) folders revealed that decisions to grant VR&E benefits appeared appropriate and were well documented. The CER folders contained specific criteria VR&E employees used to determine claimants' eligibility for benefits as well as explanations as to how the claimants' disabilities impaired their ability to obtain gainful employment. However, we noted other VR&E areas in which claims processing could be improved.

Date of Claim Timeliness – We reviewed nine claims for vocational rehabilitation benefits to determine whether the proper dates of claim were established in the BDN, and whether claims were being processed in a timely manner. All nine veterans' claims were in an "applicant" status in VR&E's Winston-Salem, Indianapolis, Newark, Roanoke, and Seattle Case Management (WINRS) Database. The applicant "begin date" recorded on the VR&E Chapter 31 master record in the BDN should reflect the date the veteran's application was received at the VAM&ROC. This is an important date because it affects the measurement of timeliness on VR&E's Balanced Scorecard (method used to monitor program and organizational performance).

Our review of the nine claims disclosed nine discrepancies. In five instances, the dates of claim recorded in the BDN system differed from the dates the veterans' applications were received at the VAM&ROC. In one instance, a pending issue had not been established. Pending issues are a critical means of controlling the veteran's case, and in certain instances, affect timeliness measured on VR&E's Balanced Scorecard. In the final three instances, VR&E general eligibility determinations were over 30 days past the date the veterans applied for benefits. Therefore, no Chapter 31 master records were established. Regional office managers were developing procedures to expedite eligibility determinations.

Forty-one veterans were on "applicant" status in the BDN. Ten veterans had been in applicant status for 6 or more months.

Documentation of Case Status - VR&E employees needed to better document case status. The VR&E Balanced Scorecard measures the time it takes for a veteran to be notified of his or her eligibility. The timeliness of notification is a very important measurement of customer service to the veteran. We reviewed eight cases of veterans who were in an "evaluation/planning" status. In four cases, there was no supporting documentation indicating that the veterans had been notified of their eligibility. Further,

review of rehabilitation plans on file in a judgment sample of 10 CER folders revealed that the achievement of individualized program goals was not adequately documented. The rehabilitation plans appeared to be “boiler-plate” documents. They did not adequately reflect the achievement of the veterans’ individualized program goals.

A veteran is considered rehabilitated when the VAM&ROC has verified that the veteran is still gainfully employed 60 days after starting employment. For the 18-month period ending December 31, 2000, VR&E’s WINRS system listed 58 veterans as rehabilitated. We reviewed case files for eight of these veterans in “rehabilitation” status. The veterans’ CER files did contain “closure statements”, meaning VR&E considered the veterans rehabilitated and employed for over 60 days. However, there was no supporting documentation indicating that either the employers or the veterans had been contacted to verify continued employment. VR&E staff indicated that in the future they would document contacts made to verify employment on the closure statement.

Regional office managers attributed many of the identified deficiencies to VR&E’s limited staffing. In November 1998, VR&E staff included a VR&E officer, a counseling psychologist, and two counseling specialists. As of January 2001, VR&E staff included only one counseling psychologist and one counseling specialist. Management was in the process of recruiting additional VR&E staff. Increased staffing should improve case management activity and documentation.

Recommendation 5. To improve VR&E case management and enhance the validity of VR&E’s Balanced Scorecard, the VAM&ROC Director should ensure that VR&E staff:

- a. Establish and process claims for vocational rehabilitation benefits in a timely manner and report accurate dates of claims in the BDN system.
- b. Accurately document veterans’ program progress in the CER folder.

Director’s Comments:

- a. Concur. Since the IG’s review of VR&E operations at this facility we have hired two additional staff in the VR&E activity which represents a 50 percent increase in staff. One of these individuals provides clerical support and has assumed all administrative and clerical activity. Her duties include establishing claims (completing form 28-1900, previously accomplished in the service center) in both the WINRS and BDN systems to insure proper and accurate control and reporting of VR&E end products, dates of claims, and other suspense issues. The VR&E staff are now very pro-active in pursuing VR&E issues to include actively seeking out pending end products, establishing them in the appropriate systems and physically hand carrying the applications to the VSRs for general eligibility determinations.
- b. Concur. With the additional support provided as mentioned above, the professional staff now have more time to devote to more technical tasks such as counseling, case management, and proper documentation of veteran’s program progress in the CER folder. Additionally, we have also followed the IG’s specific recommendation of, “documenting contacts made to verify employment on the closure statement.”

Office of Inspector General's Comments: The Director's actions and planned actions are acceptable and we consider the issue resolved.

Indicators Suggesting the Need for Management Review and Evaluation

We noted several administrative issues that warranted management attention and made suggestions for improvements in the following areas.

Strengthened controls were needed over benefits adjustments for veterans receiving long-term care at VA expense – Eligible disabled veterans are entitled to receive VA benefits payments under either the compensation program for service-connected (SC) disabilities or the pension program for NSC disabilities. Certain severely disabled veterans are entitled to an additional allowance for Aid and Attendance (A&A). VSC employees are responsible for adjusting A&A benefits for most veterans when the veterans are receiving hospital, domiciliary, or nursing home care at VA expense.

As of December 19, 2000, 48 veterans resided in the VAM&ROC's Nursing Home Care Unit (NHCU). Twelve of these 48 veterans were in receipt of A&A allowances. We reviewed current BDN records for these 12 veterans to determine whether benefits were adjustable. Benefits for 2 of the 12 veterans receiving A&A allowances had not been reduced subsequent to the veterans' admissions to the NHCU. As a result, by the time benefits in these cases are adjusted, one veteran will have been overpaid at least \$2,028 and the other at least \$346. Adjustments were not processed timely because VSC staff had not obtained required Automated Medical Information Exchange reports that would have notified them that these veterans had been hospitalized.

We concluded that the VAM&ROC Director should ensure that controls over benefit adjustments for veterans receiving care at VA expense are strengthened and that benefits for the cases identified during this review are properly reduced.

Director's Comments: We acknowledge the fact that more stringent controls were needed in order to insure proper and timely adjustment of awards based upon hospitalization at VA medical centers. This review was previously conducted by the Assistant Service Center Manager however, as part of our increased efforts to focus on inventory management, we have decided to apply a specialization approach to hospital adjustments. By assigning this special review as a specific duty to a designated VSR, we feel we will be able to accomplish these reviews in a much more controlled, timely and accurate manner.

Office of Inspector General's Comments: The Director's comments and actions address our concerns.

Controls over the completion of field examinations and accountings could be strengthened – A fiduciary is a person or legal entity charged with the duty of managing the estate of an incompetent beneficiary. The Fiduciary and Field Examination (F&FE) Unit's responsibilities include conducting field examinations and ensuring that required financial reports, known as accountings, are completed. Field examinations, conducted by F&FE staff, are performed to ascertain the needs of the beneficiary, assess the competence of the beneficiary, assess the abilities of the fiduciary, and to determine

whether funds have been properly spent. Accountings, submitted by fiduciaries, detail money received, money spent, and assets.

As of December 2000, the F&FE Unit was supervising 317 active fiduciary cases. To determine whether field examinations and accountings were completed in accordance with VA policy, we reviewed a judgment sample of 12 VA beneficiary case files.

In 3 of the 12 cases, required accountings were delinquent. In one case, a court-appointed fiduciary was 5 months delinquent in submitting the accounting for an estate that exceeded \$900,000. In another case, a spouse-payee was 4 months delinquent in submitting the accounting for an estate that had an estimated value exceeding \$15,000. In the third case, a daughter-payee was 12 months delinquent in submitting the accounting for an estate that had an estimated value exceeding \$240,000. Additionally, as of January 2001, the required field examination for this veteran beneficiary had been pending over 210 days. The daughter-payee, who is the beneficiary's legal custodian, had not been responsive to repeated contact attempts by F&FE staff. The veteran received \$4,960 each month from VA and resided with this daughter in a gated community that prevented the F&FE examiner from gaining access to the veteran without the payee leaving permission with the guards. The veteran's file revealed that he was severely incapacitated and quite vulnerable. Without completing field examinations and obtaining required accountings, the F&FE Unit cannot be assured that these beneficiaries' needs are being met and that their funds are being properly managed and safeguarded.

We also reviewed a judgment sample of 10 of the 52 field examinations conducted during the first quarter of FY 2001. The purpose of this review was to ascertain the quality and thoroughness of field examinations performed by F&FE field examiners. We found that examination reports detailed thorough and high quality field examinations. For example, a number of the beneficiaries subject to field examinations were nursing home patients. Field examiners discussed the patients' care with appropriate providers, noted the patients' living environments, and detailed the adequacy of patients' surroundings. Our review revealed no indications that field examinations were perfunctory, pre-formatted, or cursory.

We concluded that the VAM&ROC Director should ensure controls over the completion of field examinations and ensure that accountings are strengthened and take appropriate action regarding those fiduciary cases identified above.

Director's Comments: Field examinations from the beginning of the fiscal year have been most timely with 131 field exams being conducted within the designated parameters. We acknowledge the fact that our accountings could be more timely. A review of cases cited indicate the problem lies more with follow-up than with control of accountings. In several instances, efforts made to contact the payees concerning the delinquent accountings are currently among the most timely in the nation, however, a lack of response on their part is difficult to control. We will be more cognizant of award suspension actions which need to be initiated at an earlier point in the process since that is the main means of reducing payments and delinquent accounts. With respect to

the daughter payee who lives in a “gated community,” we have contacted a Special Agent from the OIG office in Newark, NJ, for some further assistance and guidance with the case.

Office of Inspector General’s Comments: The Director’s actions address our concerns.

BDN terminals left unattended – On September 22, 1999, VBA management directed all regional offices to ensure VBA staff activate their password-protected screen saver function and to log off the BDN Shell when leaving their workstations unattended. During our review, we observed a number of instances in which terminals were left unattended while logged on to the BDN Shell. Users’ command authorities become vulnerable to unauthorized access when employee terminals are not properly safeguarded. We concluded that the VAM&ROC Director should ensure that physical security over BDN terminals logged on to the BDN Shell is improved.

Director’s Comments: All workstations in the Regional Office are forced to have a screen saver activated at a minimal of 15 minutes, this however could leave the terminal unattended for at least that amount of time. Employees have been reminded of the security issues in the use of BDN Shell and have been reminded that they must log out of BDN if they leave their work area. Due to the fact no locations were given as to where the instances occurred we cannot address each specific issue. We will continue our efforts to educate our employees about the vulnerabilities BDN Shell possesses and to make them more conscious in their efforts to secure their workstations. We will utilize shortened screen saver time frames as an initial minimum measure in any case where terminal security is not observed.

Office of Inspector General’s comments: The Director’s actions address our concerns.

Fraud Prevention

Fraud and Integrity Awareness Briefings

As part of the CAP review, we conducted five 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. Two hundred and fifty-seven VAM&ROC 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. 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 are 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 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, over-billing, false claims, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, C&P 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 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 may 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.

REPORT DISTRIBUTION

VA Distribution

Secretary (00)
 Chief of Staff, Office of the Secretary (00A)
 Under Secretary for Health (105E)
 Acting Under Secretary for Benefits (20)
 Assistant Secretary for Public and Intergovernmental Affairs (002)
 Assistant Secretary for Human Resources and Administration (006)
 Assistant Secretary for Policy and Planning (008)
 General Counsel (02)
 Principle Deputy Assistant Secretary for Management (004)
 Deputy Assistant Secretary for Congressional Affairs (009C)
 Director, Management and Financial Reports Service (047GB2)
 Health Care Information Registry (10MI)
 Assistant Deputy Under Secretary for Health (10N)
 Director, Veterans Integrated Service Network (10N4)
 Director, VAM&ROC Wilmington (670/00)

Non-VA Distribution

Office of Management and Budget
 General Accounting Office
 Congressional Committees (Chairmen and Ranking Members):
 Committee on Governmental Affairs, United States Senate
 Committee on Veterans' Affairs, United States Senate
 Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations,
 United States Senate
 Committee on Veterans' Affairs, House of Representatives
 Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs,
 House of Representatives
 Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives
 Subcommittee on Benefits, Committee on Veterans' Affairs, House of
 Representatives
 Subcommittee on VA, HUD, and Independent Agencies, Committee on
 Appropriations, House of Representatives
 Staff Director, Committee on Veterans' Affairs, House of Representatives
 Staff Director, Subcommittee on Oversight and Investigations, Committee on
 Veterans' Affairs, House of Representatives
 The Honorable Joseph R. Biden, Jr., Delaware, United States Senate
 The Honorable Thomas R. Carper, Delaware, United States Senate
 The Honorable Michael N. Castle, Delaware, House of Representatives

This report will be available in the future on the VA Office of Audit Web site at
<http://www.va.gov/oig/52/reports/mainlist.htm>, List of Available Reports. This report will remain on the
 OIG Web site for 2 fiscal years after it is issued