



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Review of the VA Loma Linda Healthcare System**

## **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.

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# **Executive Summary**

## **Introduction**

From February 25 through March 1, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Loma Linda Healthcare System (VALLHCS). The purpose of the review was to evaluate selected healthcare system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 281 employees. In addition, we referred an allegation of potential conflict of interest to the OIG Hotline Division for processing. The OIG Hotline Division will pursue the allegation.

## **Results of Review**

VALLHCS patient care administration and QM activities reviewed were generally operating satisfactorily. VALLHCS management actively supported high quality patient care and performance improvement. The QM program was comprehensive and provided effective oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the VALLHCS needed to:

- Reduce excess medical supply inventories and strengthen inventory controls.
- Enhance contract administration by documenting the award process and monitoring contractor performance.
- Assign impartial staff to positions responsible for community-based outpatient clinic (CBOC) contracting activities.
- Improve QM by specifying improvement actions, tracking actions until issues are resolved, and analyzing mortality data to develop trends and patterns.
- Ensure controlled substances inspections comply with Veterans Health Administration (VHA) policy.
- Correct physical security deficiencies in the pharmacy.
- Strengthen Government purchase card controls.
- Correct deficiencies in information technology (IT) security.
- Improve controls over the Homemaker/Home Health Aide (H/HHA) Program.
- Ensure signed means test certifications are obtained from veterans.

## **Veterans Integrated Service Network 22 Director Comments**

The Veterans Integrated Service Network (VISN) 22 Director agreed with the findings and provided acceptable implementation plans. (See Appendix A, pages 16-19, for the full text of the Director's comments.) We will follow up on the planned actions until they are completed.

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

# Introduction

## Healthcare System Profile

**Organization.** Opened in 1978, the VALLHCS is based in Loma Linda, California. Outpatient care is provided at the Loma Linda facility and also at five CBOCs located in Victorville, Sun City, Palm Desert, Corona, and Upland, California. The VALLHCS is part of VISN 22 and serves a veteran population of about 290,000 in a primary service area that covers the eastern California counties of San Bernardino and Riverside.

**Programs.** The VALLHCS provides primary, tertiary, long-term, and extended care in the areas of medicine, surgery, behavioral medicine, neurology, oncology, dentistry, geriatrics, and physical medicine and rehabilitation. The VALLHCS also operates a 108-bed nursing home care unit that includes 22 rehabilitation beds.

**Affiliations and Research.** The VALLHCS is affiliated with the Loma Linda University Medical Center and Loma Linda University Health Care (LLUHC) and supports 95.5 medical resident positions in medicine, surgery, and psychiatry. Approximately 370 medical residents and 250 medical students rotate through the VALLHCS each year. The VALLHCS also supports training programs in audiology and speech pathology, dentistry, podiatry, nursing, medical records administration, social work, laboratory technology, pharmacy, respiratory therapy, psychology, physical therapy, and occupational therapy. In Fiscal Year (FY) 2001, the VALLHCS research program had 154 projects and a budget of about \$6.9 million.

**Resources.** In FY 2001, VALLHCS medical care expenditures totaled approximately \$165.4 million. The FY 2002 medical care budget was about \$174.4 million, 5.4 percent more than FY 2001 expenditures. FY 2001 staffing was 1,461.2 full-time equivalent employees (FTEE), including 100.6 physician and 268.6 nursing FTEE.

**Workload.** In FY 2001, the VALLHCS treated 42,285 unique patients, an 8.5 percent increase over FY 2000. The inpatient care workload totaled 5,172 discharges, and the average daily census was 83. The outpatient care workload was 366,500 visits.

## Objectives and Scope of CAP Review

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

**Scope.** We reviewed selected clinical, and financial and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, and financial and administrative records. The review covered the following 17 activities:

Medical Supply Inventory Management	Means Test Certifications
Service Contracts	Agent Cashier Operations
Community-Based Outpatient Clinics	Part-Time Physician Time and Attendance
Quality Management	Physical Inventory of Equipment
Controlled Substances Accountability	Primary Care Clinics
Pharmacy Security	Long-Term Care
Government Purchase Card Program	Behavioral Health
Information Technology Security	Acute Medical-Surgical Units
Homemaker/Home Health Aide Program	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction on timeliness of service and quality of care. Questionnaires were sent to all clinical employees, and 171 responded. We also interviewed 30 patients during the review. In addition, we reviewed selected VHA national performance measure data (see Appendix C, page 21). The questionnaire responses indicated high levels of patient and employee satisfaction, and did not disclose any significant issues. All questionnaire results were provided to VALLHCS management.

During the review, we also presented four fraud and integrity awareness briefings for VALLHCS employees. Two hundred eighty-one employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered VALLHCS operations for FYs 2001 and 2002 through February 2002 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VALLHCS and VISN management until corrective actions are completed.

## Results of Review

### Organizational Strengths

VALLHCS management had created an environment that supported high quality patient care and performance improvement. The patient care administration, QM, and financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

**Provider Performance was Effectively Tracked.** All facilities accredited by the Joint Commission on Accreditation of Hospital Organizations are required to collect and use provider-specific information when evaluating clinical processes and such information should be considered when the provider applies for renewal of privileges. To satisfy this requirement, the VALLHCS developed a local computer program that enables clinical managers to easily track provider performance according to mandated clinical practice guidelines. This innovative program also generates clinical reminders in the computer system, and summarizes encounter data in various formats. For a diabetic patient's annual retinal exam, this program can tabulate the percent of examinations accomplished by provider, module, and facility and also provides a graphic comparison. This program, along with the overall provider profile the VALLHCS uses, offers one of the best systems for tracking provider-specific information that we have seen.

**Physical Security of Information Technology Resources Was Generally Effective.** The VALLHCS had implemented effective controls to ensure the physical security of all IT workspace, and prevent unauthorized access to critical IT resources. Physical security for the computer room was adequate and access to IT workspace was secure and sufficiently monitored. Management conducted comprehensive risk assessments of IT resources and identified risks were properly addressed. System passwords were changed at least once every 90 days, and user access and privileges were properly controlled, evaluated, and monitored for all user accounts. In addition, IT security and awareness training was provided annually to facility personnel who had computer system access. However, IT security could also be improved by ensuring that IT duties are properly segregated and the facility's Contingency/Disaster Plan information is updated when staffing changes occur (See page 12).



## Opportunities for Improvement

### Medical Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

**Condition Needing Improvement.** The VALLHCS needed to significantly improve its management of medical supply inventories. VHA established a 30-day supply goal for medical supply inventory to lower holding costs, reduce stock outages by automating the replenishment process, and eliminate outdated items. In October 2000, VHA further required that facilities use the automated Generic Inventory Package (GIP) to manage and monitor inventories. To evaluate the effectiveness of inventory management, we compared the GIP inventory levels with the average use of each item during the 12-month period ended January 2002. We also reviewed 10 inventory items at each of the facility's 2 primary stock points, Personal Property Management (PPM) and Supply Processing and Distribution (SPD).

The VALLHCS needed to improve its monitoring of medical supply inventories to achieve the 30-day supply goal. We found the stock levels for 2,393 of 2,792 line items (86 percent) in the 2 primary stock points exceeded the 30-day supply goal. The collective value of those items exceeding the 30-day supply goal was \$743,498. Many of these items had no demand for extended periods. For example, 703 line items valued at \$308,027 had no demand during the previous 12 months.

The unnecessarily high stock levels may be attributed to the VALLHCS' limited use of the available automated tools and supply practices. The Prime Vendor Program, the GIP Inactive Item Report, the Normal Stock Level GIP feature, and bar coding and scanning equipment have been successfully used by other facilities to reduce stock levels and maintain accurate inventory records. Although PPM and SPD staff had achieved some recent success in implementing the use of the GIP Inactive Item Report to identify and reduce high stock levels, PPM and SPD staff encountered problems implementing other automated tools. Problems implementing the above mentioned automated tools were attributed to technical difficulties with automated equipment. In addition, employees did not make optimum use of modern supply acquisition practices such as the use of prime vendors.

**Recommended Improvement Action 1.** We recommended that the VISN 22 Director ensure that: (a) GIP, bar coding and scanning equipment, and prime vendors are used to maintain medical supply inventories at stock levels consistent with the 30-day supply goal; and (b) excess stock levels are reduced to a 30-day supply level. The Director concurred with the recommendation and reported that GIP, and bar coding and scanning equipment had been purchased and were currently being used for all PPM and SPD supplies and that the VISN 22 Network Business Center (NBC) would implement the use of prime vendors. The Director further indicated that the VALLHCS was in the process of reducing its medical supply inventories to a 15-day stock level.

## **Service Contracts – The Contract Award and Negotiation Process Should Be Better Documented and Contract Monitoring Should Be Improved**

**Conditions Needing Improvement.** The VALLHCS and VISN 22 NBC needed to improve the documentation of the contract award and negotiation process, and the monitoring of contracting activities. The NBC is responsible for the award, negotiation, monitoring, and oversight of VALLHCS contracts. The VALLHCS contracting officers' technical representatives (COTRs) and Fee Services Section staff assist the contracting officers in monitoring and reviewing the administrative, financial, and technical activities of service contracts. Unless an acquisition is exempt from cost or pricing data requirements, the files of contracts awarded on a noncompetitive basis should contain the cost or pricing data obtained, the analyses of such data, and a Price Negotiation Memorandum (PNM) or statement of price reasonableness that thoroughly documents the negotiation process. The basis for contractor selection for a competitive contract award should be documented. In addition, contracting officers, COTRs, and Fee Services Section staff should closely monitor and review administrative, financial, and technical activities for compliance with contract terms. To determine the effectiveness of contract negotiations, award procedures, and contract administration, we reviewed 10 VALLHCS service contracts with an estimated value of \$6.1 million. The 10 service contracts included 6 commercial item contracts, 2 basic order agreement contracts, 1 sharing agreement, and 1 enhanced sharing agreement/sales contract. Our review disclosed two weaknesses in contracting procedures that needed to be addressed.

Inadequate Contract File Documentation. The contract award and negotiation process needed to be better documented. In 9 of the 10 service contract files reviewed, documentation was deficient in 1 or more areas. These deficiencies included four contract files with no cost or pricing data and PNMs, two contract files with inadequate cost or pricing data, three contract files with no PNMs, and two contract files with no required pre-award audits. Such documentation is necessary to provide an audit trail of how the contract price was established and substantiate that a fair and reasonable price was obtained. These documents become more valuable in those instances where the Government may need to adjust the contract price upon discovering that the certified cost or pricing data submitted by the contractor was not current, accurate, and complete at the time of the contract award.

Insufficient Contract Monitoring and Oversight. The monitoring and oversight of daily contractor activities needed to be improved. For 4 of the 10 service contracts reviewed, the contracting officer had not appointed a COTR. In addition, our review of invoices disclosed two community nursing home (CNH) contracts were not adequately monitored. Specifically, our review disclosed that one CNH contractor billed a per diem rate that exceeded the contract rate, and a second CNH contractor submitted billings for pharmaceutical and laboratory costs, even though the contracted per diem rate already included these items. These inappropriate contractor billing practices resulted in overcharges of \$3,688. Invoices should be carefully screened for contractor compliance with the terms of the contract.

VALLHCS and NBC officials needed to improve contract file documentation and contract monitoring activities. NBC officials advised us that the NBC is currently drafting and updating its contracting guidelines to improve the contract award process and monitoring activities.

**Recommended Improvement Action 2.** We recommended that the VISN 22 Director ensure that: (a) contract prices are supported with cost or pricing data and analyses of such data are conducted; (b) the required pre-award audits are requested and obtained; (c) PNMs are prepared and maintained in the contract files; (d) contracting officers, COTRs, and Fee Services Section staff closely monitor contracting activities for compliance with contract terms; and (e) payments to CNH contractors for unallowable costs are recouped and future CNH contractor invoices are screened for unallowable costs. The Director agreed and reported that monitors would be established to ensure required documentation is obtained and analyzed and made available in the contract file for review. In addition, the Fee Services Section has been reorganized with changes in personnel and oversight responsibilities, and monitors have been put in place to ensure compliance with contract terms.

## **Community-Based Outpatient Clinics – Improved Contracting Practices Could Reduce Costs and Increase Availability Of Care**

**Conditions Needing Improvement.** The VALLHCS and the NBC needed to improve contracting practices used to obtain CBOC services. NBC contracting staff needed to follow the Federal Acquisition Regulation (FAR) to ensure the protection of VA's contractual interests and the fairness and reasonableness of capitated rates for CBOC services. Improvements in contracting practices and adherence to the FAR could result in reduced CBOC contract costs and allow more patients to receive care at VALLHCS CBOCs.

The VALLHCS obtains services for their five CBOCs through contracts with LLUHC. Our review focused on the three largest CBOC contracts awarded to LLUHC for about \$13.9 million to determine if they had been properly awarded and administered. Each contract included a base year plus four option years. Weaknesses in CBOC contracting procedures were identified in three areas.

Appearances of Conflict of Interest Needed to Be Avoided. An appearance of a conflict of interest developed in the award and administration of the CBOC contracts because the VALLHCS Vice President (VP) of Ambulatory Care and Health Analysis is the COTR for the CBOCs, and also an uncompensated associate professor at Loma Linda University. As the COTR, the VP helped evaluate the reasonableness of the LLUHC proposed capitated rates before the contracts were awarded. After the award of the contracts, the VP routinely received invoices and certified payments for the services provided by the LLUHC staff at the CBOCs (no inappropriate payments were identified). VHA policy prohibits employees from taking official action on behalf of VA in a contract with an affiliated university when the employee may have a "personal and substantial" interest in the contract. This prohibition applies even though the employee may not receive any financial benefit arising from the contract between VA and the affiliated university, because the law referred to in the VA policy attaches the affiliated university's financial interest in the contract to the employee. To address this problem, the

VALLHCS and NBC agreed to reassign the COTR position to an individual who is not affiliated with LLUHC.

Improved Contracting Practices Needed to Be Implemented. The contracting officer for the CBOC contracts had not prepared justifications for the use of sole source contracts and PNMs. VA's preferred method of awarding a contract is through full and open competition to ensure a fair and reasonable contract price is obtained. When a contracting officer is planning to deviate from this preferred method by acquiring products or services through a sole source, then a justification for other than full and open competition (JOFOC) must be prepared. In the absence of a JOFOC, VA cannot guarantee that funds were used judiciously. In addition, the negotiation strategies and cost elements used to establish the CBOC capitated rates had not been documented in PNMs so that an independent assessment of the fairness and reasonableness of the rates could be completed. As noted previously, the NBC is drafting and updating its contracting guidelines to address the contract administration and monitoring activities, such as the lack of PNMs and JOFOCs.

Adequate Price Analyses Were Needed. The contracting officer needed to perform adequate price analyses to ensure that fair and reasonable capitated rates were negotiated. Although no formal price analyses were available, the contracting officer and COTR stated that they had assessed the fairness and reasonableness of the capitated rates by benchmarking the LLUHC's proposed CBOC rates with CBOC rates from other VHA facilities, and the Medicare rate. We determined that the benchmarking process using rates from other VHA facilities was not reliable because the contracting officer did not obtain cost breakdowns to identify the specific costs and expenses included in the facilities' capitated rates. As a result, there was no assurance that the contracting officer was benchmarking the capitated rates of comparable CBOC contracts. Similarly, the Medicare rate was not an accurate benchmark because Medicare patients are high-cost patients who are generally 65 years or older with serious, chronic health problems requiring constant medical attention. In contrast, the VALLHCS' CBOC business plan estimated that only about 33 percent of the veterans at one of its biggest and busiest clinics, Palm Desert, would be 65 or over. Therefore, the majority of the CBOC's patients (67 percent) would probably require only non-routine/preventive medical care and have lower medical costs than those of a typical Medicare patient.

Improvements in price analyses are necessary to ensure an accurate and objective assessment of the capitated rates. Better price analyses are needed to accurately assess the fairness and reasonableness of capitated rates and could allow the negotiation of lower CBOC capitated rates. VALLHCS and NBC officials need to thoroughly explore the possibility of negotiating lower rates, since financial constraints have caused the VALLHCS to cap patient enrollment at three of its five CBOCs. As of March 2002, about 380 veterans had been placed on CBOC waiting lists and had been asked to travel to the VALLHCS for care while they wait for space at their closest CBOC to become available. The NBC is evaluating its contracting practices and plans to distribute guidelines to staff to ensure price analyses are conducted in accordance with FAR and VA contracting requirements. These actions should improve the contracting officer's negotiation position and secure fairer and more reasonable contract prices.

**Recommended Improvement Action 3.** We recommended that the VISN 22 Director ensure that: (a) the CBOC COTR position is reassigned to an individual not affiliated with the LLUHC; (b) sole source justifications and PNMs are prepared, when applicable; and (c) adequate price analyses are performed for capitated CBOC contract rates and where indicated, rates are renegotiated. The Director agreed and reported that the CBOC COTR position had been reassigned. The Director further indicated that rates were being renegotiated with LLHCU and that comparison rates would be obtained and analyzed and if indicated, sole source justifications would be completed.

## **Quality Management – VALLHCS Managers Need To Improve Follow-up On Action Items and Mortality Data Needs To Be Analyzed**

**Conditions Needing Improvement.** The VALLHCS' QM program was comprehensive and provided appropriate oversight of patient care. However, managers did not consistently present data, state specific actions, or follow-through on action items identified in QM reviews. Managers also did not analyze mortality data to establish trends or patterns. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files. We identified two issues that needed to be addressed.

Identify Action Items and Follow-through Until Resolution. VALLHCS managers did not clearly state actions to take when performance measures presented improvement opportunities. For example, although patient complaint data was collected and analyzed, they were not presented or discussed at any committee meeting for a 12-month period. In addition, the Performance Improvement Committee chartered a performance improvement team and accepted the team's specific recommendations, but did not follow-through with implementation of their recommendations. VALLHCS managers did not consistently follow up on action items reported in QM reviews, such as utilization management. The results of QM reviews needed to be presented to a committee meeting at the appropriate level, addressed with appropriate action items assigned to specific responsible managers, and tracked until resolution was achieved. The Healthcare Quality Improvement (HQI) Chief agreed that the VALLHCS needed a more effective process and informed us that senior managers were in the process of making changes to their committee structure to better manage the flow of data. Managers will also make changes to the format of minutes of meetings and the tracking of follow-up action items.

Mortality Data Analyses Were Needed. Per guidance from the Chief Network Officer dated April 27, 2000, each medical facility is expected to analyze mortality data to determine if any trends or patterns exist. The HQI Chief was unaware of the requirement and agreed to initiate the analysis.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that: (a) all significant action items are monitored until resolutions are achieved; and (b) mortality data is analyzed for trends or patterns. The Director agreed and reported that all action items would be monitored and that mortality data would be monitored and trended.

## **Controlled Substances Accountability – Controls Should Be Strengthened**

**Conditions Needing Improvement.** The VALLHCS needed to address weaknesses in the unannounced controlled substances inspection program and pharmacy inventory verification process. Inspectors are required to conduct monthly unannounced inspections to ensure they are able to account for all controlled substances. Also, controlled substances located in the pharmacy should be verified every 72 hours. To assess controlled substances accountability, we reviewed inspection reports for the 13-month period ended January 2002; interviewed responsible staff; conducted a physical count of sampled items located in three areas where controlled substances were dispensed and stored; and toured and physically inspected drug storage areas. We identified seven weaknesses in inspection and inventory procedures.

- The monthly controlled substances inspection program did not include inspections of all areas where controlled substances were maintained. There should have been 300 inspections (25 inspection areas multiplied by 12 months) conducted during Calendar Year 2001. However, 75 inspections were not conducted and 27 inspections were not conducted in a timely manner.
- Inspection procedures did not ensure that all controlled substances were included in the inspection process. We found excess, outdated, and unusable controlled substances were not included in the inspection of the pharmacy until February 2002.
- Inspectors did not review the 72-hour pharmacy inventory verification reports.
- An inspection conducted of the pharmacy in February 2001 identified large discrepancies. For example, the recorded balance of Diazepam (10 milligram tablets) was 7,300, but the actual count was 9,000. The pharmacy staff stated this discrepancy occurred because they had received a shipment of Diazepam that had not been recorded. Although the pharmacy staff resolved these discrepancies the next day, the inspector did not return to verify the resolution of the discrepancies.
- The inspections were unannounced, but were performed at predictable times. The required element of surprise was nullified, since the inspections were usually conducted during the last week of the month.
- The pharmacy staff only conducted 72-hour inventory verifications in the main controlled substances pharmacy vault. Verifications were not performed for the remaining three controlled substances pharmacy storage areas. These storage areas included the outpatient controlled substances dispensing room, a safe containing methadone, and a cabinet that is used by staff after normal business hours.
- Our physical count of 10 controlled substances stored in the pharmacy disclosed a discrepancy in the outpatient dispensing room. We discovered the physical count of one controlled substance exceeded the recorded amount by one tablet. This discrepancy

might not have otherwise been discovered until the next monthly-unannounced inspection.

The primary cause for the inspection deficiencies was a local policy that did not comply with current VHA policy for conducting unannounced controlled substances inspections. For example, the inspectors did not perform the procedures reflected in current VHA policy, such as review of the 72-hour pharmacy inventory verification reports, because they followed the local policy that did not require it. The inventory verification problem occurred because pharmacy staff were unaware that all controlled substances in the pharmacy had to be verified every 72 hours. Updated policies and procedures would provide the inspection and pharmacy staff a better understanding of the standard operating procedures and improve the controls over controlled substances.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that the VALLHCS controlled substances inspections and inventory verification policies and procedures are updated to reflect current VHA policy and that the policies and procedures are followed. The Director agreed and reported that controlled substances inspections policies and procedures were being evaluated to ensure compliance with VHA requirements and that Pharmacy Service would increase the frequency of inventories.

## **Pharmacy Security – Physical Security Should Be Improved**

**Conditions Needing Improvement.** The VALLHCS needed to improve physical security in the pharmacy. VHA facilities are required to maintain effective security controls to prevent unauthorized access to controlled substance storage areas and ensure all controlled substances are physically secure. To evaluate pharmacy security controls, we visited and inspected pharmacy dispensing and storage areas; reviewed security policies and procedures; and interviewed pharmacy and security personnel. We identified five security weaknesses that needed to be addressed.

- The outpatient pharmacy dispensing room walls were not covered or embedded with steel security mesh as required by VA. One of the walls separated the pharmacy from a public corridor. In addition, this room had two large windows made of ordinary window glass rather than the required security glass.
- The outpatient pharmacy dispensing room had Schedule III narcotics stored on open shelving, rather than in required locked steel cabinets.
- The pharmacy had no alarm system, including motion detectors for after-hours security, and no panic buttons.
- The main controlled substances pharmacy vault and the outpatient pharmacy dispensing room each had two video security cameras installed. However, three of the four cameras (one in the vault and two in the dispensing area) were not functioning. The non-functioning cameras were not discovered until our inspection of the pharmacy.

- A door leading into the main pharmacy did not have electronic key access, and the physical lock had not been changed when employees terminated their employment.

Pharmacy staff were not familiar with the physical security requirements, such as required construction materials and alarm systems. Police and Security Service is responsible for facility security. The VALLHCS recently appointed a new Chief, Police and Security Service, who advised us that he intended to perform a complete security survey of the pharmacy and address identified deficiencies.

**Suggested Improvement Action.** We suggest that the VISN 22 Director ensure that: (a) construction materials in the pharmacy comply with VA policy; (b) Schedule III narcotics are stored in locked steel cabinets; (c) the pharmacy is equipped with the required security equipment, including an alarm system, electronic key access, motion detectors, and panic buttons; (d) security equipment is fully functional; and (e) locks are changed when employees terminate their employment. The Director agreed and reported that funds had been allocated to correct construction and security equipment deficiencies. The Director further reported that a locked steel cabinet had been obtained for the storage of Schedule III narcotics, and that pharmacy door locks would be changed when employees terminate their employment.

## **Government Purchase Card Program – Purchase Card Controls Should Be Strengthened**

**Conditions Needing Improvement.** The VALLHCS needed to improve controls over the Government purchase card program. VHA prohibits cardholders initiating any individual purchases exceeding \$2,500 unless the head of the Contracting Activity grants the appropriate warrants. VHA further requires that 75 percent of Government purchase card reconciliations be completed within 10 days, and 95 percent be completed within 17 days, and that the Government Purchase Card Program Coordinator, Billing Office official, and Dispute Officer duties be properly segregated. The FAR also prohibits Government purchase card purchases from being split to circumvent the \$2,500 threshold. Additionally, approving officials are responsible for acquisition training, appointing cardholders, recommending cardholder purchase limits, monitoring cardholders, certifying cardholder transactions and ensuring applicable documentation is maintained, and ensuring policies are followed.

To evaluate Government purchase card program controls, we interviewed the Program Coordinator and reviewed Government purchase card transactions and records. We identified three weaknesses in the Government purchase card program controls that needed to be addressed.

**Contracting Warrants.** Six VALLHCS employees, who did not have the appropriate contracting warrants, exceeded their \$2,500 transaction limits and made six purchases totaling about \$36,522. Cardholders who make purchases above \$2,500 are required to complete a 40-hour training course on acquisition policies and procedures, and obtain warrants that allow them to spend up to, but not exceed, specific higher dollar limitations. Such controls are in effect to ensure the most fair and reasonable price is obtained and to protect VA's interests.



Government Purchase Card Reconciliations. VHA requires cardholders to reconcile Government purchase card orders promptly by having 75 percent of the payments reconciled within 10 calendar days, and 95 percent of the payments reconciled within 17 calendar days. The purchase card reconciliations reviewed for the 4-month period ended January 2002 were not always completed within the required 17 days. Of the 33,463 payments valued at about \$16.3 million, 29,321 (88 percent) were reconciled within 17 days. The alternate Government Purchase Card Coordinator had reported the delinquent purchase card reconciliations to the responsible officials. However, these officials did not follow-up with cardholders to ensure reconciliations were completed in a timely manner.

Separation of Duties. The duties and responsibilities of the Government purchase card program staff were not properly segregated. First, the Program Coordinator duties were not segregated from those performed by the Billing Office official for all transactions. Second, approving officials reconciled and certified the Government purchase card reconciliations for 22 cardholders, even though their responsibilities were limited to certifying transactions. This process involved 238 transactions totaling \$79,932. We determined that 15 of the 22 cardholders were no longer employed by the VALLHCS, or were on leave when the reconciliations occurred. The Program Coordinator did not know the status of the remaining seven cardholders during the time this activity occurred. The Program Coordinator recognized such duties were incompatible and agreed to appoint an alternate approving official to approve transactions when cardholders are absent or have been terminated.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that: (a) Government purchase card program staff comply with FAR and VHA requirements; (b) reconciliations and approvals are performed in a timely manner; (c) an alternate approving official be appointed when the approving official has to perform Government purchase card reconciliations; and (d) the Program Coordinator does not perform Billing Office official duties and responsibilities. The Director agreed and reported that the Chief Financial Officer (CFO) had trained staff in all services to ensure that users were familiar with FAR and VHA requirements. Further, the CFO would continue to monitor for compliance with these requirements. Two alternate approving officials had been appointed to ensure proper segregation of duties.

## **Information Technology Security – Strengthened Controls Are Needed**

**Conditions Needing Improvement.** Although the physical security of IT resources was generally effective, the VALLHCS needed to improve controls over the Information Security Officer (ISO) function and the Contingency/Disaster Plan. Automated information systems security policy and guidelines recommend separation of the ISO function from the Information Technology Service (ITS). VA also requires the Contingency/Disaster Plans of each facility to be documented and continually updated since the personnel responsible for implementation of the plan and other factors may change. We identified two weaknesses in information security that needed to be addressed.

- The ISO reported to the VALLHCS Chief Executive Officer, but also performed day-to-day duties in ITS, and was supervised by the Director, ITS. The Director, ITS, had not identified duties in ITS that could be incompatible with the ISO's duties and responsibilities. Key positions must be properly segregated to prevent a single individual from having too much control and the ability to initiate, develop, implement, and approve changes to a system or process. If the proper controls are not in place, then the risk of being exposed to problems will remain high. Accordingly, controls should be enhanced by ensuring the IT functions performed by the ISO, will in no way, be associated with his or her responsibilities to develop, implement, and monitor information security policy and procedures.
- The key personnel directory included in the Contingency/Disaster Plan was outdated. In the event of an emergency, personnel would not be able to contact the current Director, ITS, the ISO, or the Chief of Police and Security Service, since the names and telephone numbers in the directory for these positions were for former employees.

The responsible IT officials agreed policies and procedures needed to be improved to ensure duties of key positions are properly segregated, and that the Contingency/Disaster Plan needed to be updated and periodically verified for accuracy. These improvements should correct the weaknesses identified.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that: (a) ITS establishes a policy that identifies ITS duties that are incompatible with ISO duties; and (b) the key personnel directory of the Contingency/Disaster Plan is updated when staffing changes occur. The Director agreed and reported that VALLHCS management would work with the Director, ITS to ensure the ISO would have no incompatible duties and that a current key personnel directory for the Contingency/Disaster Plan had been completed and distributed.

## **Homemaker/Home Health Aide Program – Clinical and Administrative Procedures Could Be Improved**

**Conditions Needing Improvement.** The VALLHCS needed to improve clinical and administrative policies and procedures governing the H/HHA Program. The H/HHA Program was designed to provide functionally impaired veterans in-home support with bathing, dressing, and mobility. The underlying goal of the program was to keep veterans in their homes, rather than in nursing homes. VHA is currently in the process of evaluating program results and revising the H/HHA Program policies and procedures. The initial VHA program directive that expired in December 1997 required that services be acquired from public and private sources. However, VHA facilities would still be responsible for overall case management. In addition, private sources providing services to veterans were required to be licensed.

To assess H/HHA Program processes and controls, we reviewed medical records of 10 participating veterans, interviewed program officials and 5 veterans enrolled in the program, and analyzed 24 invoices for services. We identified three weaknesses that needed to be addressed.

Assessments for H/HHA Services Were Not Documented. Medical records did not contain assessments of veterans' eligibility for H/HHA services as required by VHA. An interdisciplinary assessment should be documented in the veteran's medical record and should reflect the clinical need and administrative eligibility for H/HHA services. The 10 medical records we reviewed did not contain such data. Despite the missing data in the medical records, we were able to determine through other means that veterans met the eligibility requirements. The H/HHA Program Director indicated assessments were only documented when an inpatient was discharged. To facilitate a smooth transition of services, the assessment team should provide the H/HHA provider a complete referral packet containing the clinical needs and administrative eligibility of a patient.

Performance Improvement Data and Patient Reassessments Were Deficient. We found no evidence that the VALLHCS used Community Health Agency (CHA) performance improvement data and patient quarterly reassessments to evaluate the quality of care, and need for continued care. Responsible officials indicated that they had not required the CHAs to submit quarterly summaries of their activities and quarterly reassessments documenting the clinical need of H/HHA services for each patient. Patient reassessments were completed by the H/HHA Program Director every six months, but only to satisfy requirements of the fee basis program. CHAs should be required to submit performance improvement data and patient reassessments on a quarterly basis to enable the VALLHCS to monitor CHA activities and to determine if current and future services are warranted.

Program Oversight Function Did Not Exist. The VALLHCS did not have a program oversight function in place to monitor H/HHA Program activities as required by VHA. Such programs should have controls in place to ensure compliance with policy, monitor activities, and safeguard resources. Specifically, we found an interdisciplinary steering committee had not been established to monitor program operations, workload, fund management, and quality of care issues. Also, the VALLHCS did not have a policy covering these activities.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that: (a) a complete interdisciplinary assessment for H/HHA Program services is documented for every patient referred to the H/HHA Program; (b) CHA performance improvement data and patient reassessment reports are obtained on a quarterly basis, and reviewed for quality of care and continued service issues; and (c) program oversight functions, such as a policy and steering committee, be established to safeguard the program. The Director agreed and reported that the VALLHCS would develop a system to ensure that an interdisciplinary assessment is completed for every patient referred to the H/HHA Program and that performance improvement data and patient reassessment reports are obtained on a quarterly basis and reviewed for quality of care and the need for continued services. In addition, a steering committee had been reinstated to provide oversight for CHA quality of care and continued services issues.

## **Means Test Certifications – Patient Income Data Needs to Be Obtained**

**Condition Needing Improvement.** The VALLHCS needed to increase Medical Care Cost Fund collections by ensuring that means test certifications are obtained for all required patients. Veterans who may be subject to medical co-payments must provide VA with family income data (means test) and health insurance information annually. Such data is used to determine a veteran's ability to pay for medical care. If a signed means test certification is not on file, the VALLHCS cannot verify the veteran's income data, and unpaid co-payments cannot be collected from tax refunds.

We reviewed 46 of 595 administrative files of veterans who had reported zero income for the first quarter of FY 2002 and were required to complete the means test certification forms. Seven (15 percent) of the administrative files did not contain current means test certifications. VALLHCS officials attributed two of the missing means test certifications to processing problems by CBOC personnel. The officials could not explain the cause of the remaining five missing means test certifications. VALLHCS officials planned to address the CBOC problem by providing additional training on means test certification procedures to CBOC personnel. This training should also be provided to all personnel involved in the means test certification process to address the problems associated with the remaining missing certifications. In addition, the planned installation of a software patch in the computer system should prevent appointments from being scheduled if a current means test certification is not in the computer system.

**Suggested Improvement Actions.** We suggested that the VISN 22 Director ensure that all responsible VALLHCS and CBOC personnel receive training emphasizing the importance of obtaining completed and signed means test certifications for all appropriate veterans on an annual basis. The VISN 22 Director agreed and reported the software had been installed on May 10, 2002, to ensure that means tests are performed on all veterans prior to treatment.

## VISN 22 Director Comments

## Memorandum



Jerry L. Pettis  
Memorial  
VA Medical  
Center  
Loma Linda, CA

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VA Greater  
Los Angeles  
Healthcare System  
Los Angeles, CA

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VA Long Beach  
Healthcare System  
Long Beach, CA

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VA San Diego  
Healthcare  
System  
San Diego, CA

~

VA Southern  
Nevada  
Healthcare  
System  
Las Vegas, NV

~

Kenneth J. Clark  
Network Director  
5901 E 7<sup>th</sup> St  
Long Beach, CA  
90822

Date: July 3, 2002

From: Network Director, VA Desert Pacific Healthcare Network (10N/22)

Subj: Response to OIG CAP review of the VA Loma Linda Healthcare System

To: Assistant Inspector General for Auditing (52)

Thru: Deputy Under Secretary for Health for Operations & Management (10N)

1. I have reviewed the Combined Assessment Program (CAP) review of the VA Loma Linda Healthcare System and appreciate the assistance offered by Mr. Julio Arias to discuss any questions we had while preparing this response. Through subsequent discussions with facility leadership at the VA Loma Linda Healthcare System, we concur with the findings and submit the following response to address each recommendation and suggested improvement:

**Recommended Improvement Action 1.** *We recommend that the VISN 22 Director ensure that: (a) GIP, bar coding and scanning equipment, and prime vendors are used to maintain medical supply inventories at stock levels consistent with the 30-day supply goal; and (b) excess stock levels are reduced to a 30-day supply level.*

**(a) Concur.** GIP, bar-coding and scanning equipment have been purchased and are in use for all SPD/Materiel Management supplies. We are in agreement with the recommendation to utilize Prime Vendors when that program has been made available for use by the National Acquisition Center. The Network Business Center has been notified to begin implementation at that time.

**(b) Concur.** At the time of the CAP site visit, Loma Linda had fifty-one (51) days' inventory in the warehouse and SPD. Remarkable efforts have been made to reduce their existing inventory to fifteen (15) days, which is well below the mandated 30 day supply goal. Loma Linda continues to have a backlog in processing paper inventory transactions. The Chief Financial Officer continues to work with staff to systematically reduce this backlog which is expected to be completed within the next 60 days. In addition, Loma Linda purchased Omnicell Systems for several wards and plans to continue purchasing these for remaining units as their budget allows to further enhance inventory control processes.

**Recommended Improvement Action 2.** *We recommend that the VISN 22 Director ensure that (a) contract prices are supported with cost or pricing data and analyses of such data are conducted; (b) the required pre-award audits are requested and obtained; (c) PNMs are prepared and maintained in the contract files; (d) contracting officers, COTRs, and fee service section staff closely monitor contracting activities for compliance with contract terms; and (e) payments to CNH contractors for unallowable costs are recouped and future CNH contractor invoices are screened for unallowable costs.*

**Concur with Actions (a),(b) and (c).** By regulation, these are procedures we historically adhere to. We will immediately implement a process to ensure they are monitored more closely, and that appropriate documentation is available in the contract file for review, and are easily accessible.

**Concur with Actions (d) and (e).** The fee services section, under the Office of the Chief of Staff at Loma Linda, has been reorganized with changes in personnel and oversight responsibilities. All processes are being systematically reviewed and a thorough financial analysis is being conducted by the Operations Director (COS Office) at Loma Linda in consultation with the Chief Financial Officer. Monitors have been put in place, which include Network-wide COTR training to assure compliance with contract terms.

**Recommended Improvement Action 3.** *We recommend that the VISN 22 Director ensure that: (a) the CBOC COTR position is reassigned to an individual not affiliated with the LLUHC; (b) sole source justifications and PNMs are prepared, when applicable; and (c) adequate price analyses are performed for capitated CBOC contract rates and where indicated, rates are renegotiated.*

**(a) Concur.** The Operations Director (COS Office) at Loma Linda, will be appointed as the responsible administrative oversight official. It is believed that a number of the existing responsibilities that were assumed by Dr. Evans as the COTR will be balanced between Ms. Previte and the NBC Contracting Officer, which we anticipate will avoid potential conflict of interest issues.

**(b and c) Concur.** Rates are currently being renegotiated with Loma Linda University. Comparison rates will be obtained and analyzed with sole source justifications completed, if indicated.

**Suggested Improvement Actions.** *We suggest that the VISN 22 Director ensure that: (a) all significant action items are monitored until resolutions are achieved; and (b) mortality data are analyzed for trend patterns.*

**(a) Concur.** All action items will be monitored at the Loma Linda facility and as necessary through the appropriate Network Council. **(b) Concur.** The LL Healthcare Quality Manager is aware of this recommendation and is collaborating with the Risk Manager to assure that we are in compliance with most recent directives from VACO relating to the monitoring and trending of mortality data.

**Suggested Improvement Action.** *We suggest that the VISN 22 Director ensure that the VALLHCS controlled substances inspections and inventory verification policies and procedures are updated to reflect current VHA policy and that the policies and procedures are followed.*

**Concur.** Pharmacy and Management staff are in the process of evaluating all of our current policies and procedures relating to controlled substances inspections to assure that Loma Linda is in compliance with VA Regulations. Pharmacy Service will increase the number of internal inspections as required.

**Suggested Improvement Actions.** *We suggest that the VISN 22 Director ensure that (a) construction materials in the pharmacy comply with VA policy; (b) Schedule III narcotics are stored in the required locked steel cabinets; (c) the pharmacy is equipped with the required security equipment, including an alarm system, electronic key access, motion detectors, and panic buttons; (d) security equipment is fully functional; and (e) locks are changed when employees terminate their employment.*

**(a) Concur.** During recent renovation of the pharmacy, one wall was inadvertently not reinforced with appropriate material. At the present time, the Chief, Pharmacy is working with FMS to reinforce one wall with steel mesh to assure that unauthorized persons cannot gain entrance by permeating the current wall

wall. In addition, a window in the pharmacy will also be reinforced. Funds have been allocated for this project. **(b) Concur.** A locked steel cabinet has been obtained and Schedule III narcotics are being stored as required. **(c and d) Concur.** Funds have been allocated and plans are underway to purchase security system and all required security equipment. **(e) Concur.** At the present time, locks are being changed if employees leave. We are exploring the possibility of utilizing key pads rather than actual keys.

**Suggested Improvement Actions.** *We suggest that the VISN 22 Director ensure that: (a) government purchase card program staff comply with the FAR and VHA requirements; (b) reconciliations and approvals are performed in a timely manner; (c) an Alternate Approving Official be appointed when the approving official has to perform Government purchase card reconciliations; and (d) the Program Coordinator does not perform Billing Office Official duties and responsibilities.*

**(a)** The Chief Financial Officer has personally trained staff in all services to assure that users are familiar with FAR and VHA requirements. Monitoring by CFO is ongoing. **(b) Concur.** At the time of the site visit, Loma Linda had 522 unreconciled purchases. After training and interventions by CFO, this number is now at 148 and is anticipated to further decrease over the next several months. **(c and d) Concur.** Two Alternate Approving Officials have been appointed.

**Suggested Improvement Actions.** *We suggest that the VISN 22 Director ensure that: (a) ITS establishes a policy that identifies ITS duties that are incompatible with ISO duties; and (b) the key personnel directory of the Contingency/Disaster Plan is updated when staffing changes occur.*

**(a) Concur.** At the present time, the position of ISO is vacant (former 2 ISOs have been recruited for V22/VACO positions). Management will work with Chief, IT to assure that ISO position is appropriately placed in organization (possibly outside of ITS) so that there are no incompatible duties. **(b) Concur.** Key personnel directory for Contingency/Disaster Plan has been completed and distributed as appropriate.

**Suggested Improvement Actions.** *We suggest that the VISN 22 Director ensure that: (a) complete interdisciplinary assessment for H/HHA Program Services is documented for every patient referred to the H/HHA Program; (b) CHA performance improvement data and patient reassessment reports are obtained on a quarterly basis, and reviewed for quality of care and continued service issues; and (c) program oversight functions, such as policy and steering committee, be established to safeguard the program.*

**(a and b) Concur.** The Operations Manager (COS Office) in conjunction with the facility's Home Health Referral Liaison will develop a system to ensure an interdisciplinary assessment for every patient referred to the H/HHA Program. The Home Health Referral Liaison will ensure that performance improvement data and patient reassessment reports are obtained on a quarterly basis and reviewed for quality of care and continued service issues. **(c)** A Steering Committee has been reinstated and will assume oversight responsibilities for all CHA quality of care and continued service issues.

**Suggested Improvement Action.** *We suggest that the VISN 22 Director ensure that all responsible VALLHCS and CBOC personnel receive training emphasizing the importance of obtaining completed and signed means test certifications for all appropriate veterans on an annual basis.*

**Concur.** Means Test Blocking was installed at Loma Linda on May 10, 2002 to assure that Means Tests are performed on all patients prior to treatment.

2. I hope that this response addresses the concerns raised. If you need clarification or further information, please do not hesitate to contact Kalautie JangDhari, Network Operations Officer at

**Appendix A**

(562) 826-5963 or Anne Gillespie, Associate Director for Nursing/Patient Care Services at the VA Loma Linda Healthcare System at (909) 422-3005.

A handwritten signature in blue ink, appearing to be "Anne Gillespie", written in a cursive style.



## Monetary Benefits in Accordance with IG Act Amendments

**Report Title:** Combined Assessment Program Review of the VA Loma Linda Healthcare System

**Report Number:** 02-00988-170

<u>Recommendation</u>	<u>Explanation of Benefit[s]</u>	<u>Better Use of Funds</u>
1	Better use of funds by achieving 30-day supply goal.	\$743,498
2	Better use of funds by screening invoices for unallowable costs.	<u>3,688</u>
	Total	\$747,186

## VHA National Performance Measures

This table includes a selection of items from the VHA National Performance Measurement System.\*

<b>Measure</b>	<b>Facility Results 4<sup>th</sup> Quarter FY 2001</b>	<b>VHA Results FY 2001</b>	<b>VHA Goal FY 2002</b>
1. Percent of patients receiving timely colorectal cancer screening during primary care visit(s) by fecal occult blood test, sigmoidoscopy, or colonoscopy within designated timeframes.	60	60	65
2. Percent of patients screened for high risk factors for hepatitis C such as blood transfusions, injection illicit drug use, and tattoos.			
a. Primary care	97	51	60
b. Mental health	94	N/A	60
3. Percent of patients receiving immunizations against pneumococcal disease.			
a. Home based primary care	N/A	85	90
b. Spinal cord injury/disorder	N/A	N/A	90
4. Percent of patients with Diabetes Mellitus who receive a retinal exam from an eye care specialist within designated timeframes.	72	66	70
5. Percent of patients using tobacco who have been counseled 3 times in 12 months to cease tobacco use.			
a. Primary care	71	62	68
b. Mental health	67	N/A	68
6. Percent of pharmacy orders entered into the computerized patient record system by the prescribing clinician.	45	74	85
7. Average processing time for compensation and pension exams 35 days.	45 days	33.22 days**	35 days

\* OIG Healthcare Inspectors did not independently validate this data.

\*\*Average processing time as of December 2001.

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**Appendix D**

Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives  
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans'  
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**This report will be available in the near future on the VA Office of Audit Web site at <http://www.va.gov/oig/52/reports/mainlist.htm>, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.**