Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

Report No 03-02420-06 October 14, 2003

VA Office of Inspector General
Washington, DC 20420

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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Introduction

During the week of August 4-8, 2003, the OIG conducted a CAP review of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 4 fraud and integrity awareness briefings to 150 employees.

Results of Review

The performance of the Dysphagia Team represented an organizational strength. Clinical laboratory security and environment of care were adequate, and management of controlled substances, personal funds of patients, and part-time physician time and attendance was satisfactory. To improve operations, we recommended that the Veterans Integrated Service Network (VISN) 6 Director require the medical center Director to improve:

- Administration of contracts for special transportation.
- Controls over the Government Purchase Card Program.
- Controls over the Agent Cashier function.
- Distribution and acknowledgement of receipt of conflict of interest rules.
- Automated information systems (AIS) security.

We also suggested that the VISN Director require the medical center Director to improve the Supervised Private Home and QM Programs.

VISN Director Comments

The VISN and medical center Directors agreed with the findings, recommendations, and suggestions and provided acceptable implementation plans. (See pages 10-15 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in Salisbury, North Carolina, the W.G. (Bill) Hefner VA Medical Center is a primary and secondary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at an outpatient clinic (OPC) located in Winston-Salem, North Carolina, and a community-based outpatient clinic (CBOC) located in Charlotte, North Carolina. The medical center is part of VISN 6, and serves a veteran population of about 247,000 in a primary service area that includes 24 counties in the Piedmont Region of North Carolina.

Programs. The medical center provides medical, surgical, mental health, and geriatric rehabilitation services. The medical center has 159 hospital beds, 270 Nursing Home Care Unit (NHCU) beds, and operates several regional referral and treatment programs, including a Post-Traumatic Stress Disorder Unit, a Substance Abuse Residential Rehabilitation Treatment Program, and a Psychiatric Intensive Care Unit.

Affiliations and Research. The medical center is affiliated with the Wake Forest University School of Medicine and supports three medical resident positions. In Fiscal Year (FY) 2002, the medical center research program had 15 projects and a budget of $254,000. Key areas of research include rehabilitation of functional impairments associated with low vision and blindness, age-related memory loss, and prostate cancer.

Resources. In FY 2002, medical care expenditures totaled $128 million. The FY 2003 medical care budget is $137 million. FY 2002 staffing totaled 1,222 full-time equivalent employees, including 57 physicians and 418 nurses.

Workload. In FY 2002, the medical center treated 40,337 unique patients, and provided 49,086 inpatient days of care in the hospital and 81,272 in the NHCU. The inpatient care workload included 2,582 discharges, and the average daily census was 134 for the hospital and 223 for the NHCU. The outpatient care workload in FY 2002 was 228,725 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, 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, 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. The CAP review covered medical center operations from January 1, 2001, through August 8, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Agent Cashier	Environment of Care
Automated Information Systems Security	Government Purchase Card Program
Clinical Laboratory Security	Part-Time Physician Time and Attendance
Conflicts of Interest	Patient Waiting Times
Contract Award and Administration	Personal Funds of Patients
Controlled Substances Security	Quality Management
Dysphagia Team	Supervised Private Home Program

An activity that was particularly effective or otherwise noteworthy is recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-9). For these activities, we make recommendations or suggestions. 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 VISN and medical center management until corrective actions are completed. For those activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Over 90 percent of the patients responding to the survey rated the quality of care provided as good or excellent, and more than 88 percent reported that they would recommend the medical center to eligible family members or friends. The survey results were provided to medical center management.

During the review, we presented 4 fraud and integrity awareness briefings to 150 medical center employees. The briefings 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.

Results of Review

Organizational Strengths

Dysphagia Team

Dysphagia Team Actions Represented an Aggressive Approach to the Management of a High-Risk Population. Patients with dysphagia (difficulty swallowing) are at increased risk for aspiration, malnutrition, and dehydration. VA medical centers are not required to have a dysphagia committee. However, the medical center's Dysphagia Team was interdisciplinary and functioned as a committee, which met quarterly and reported to the Nutrition Committee. The Dysphagia Team had developed performance improvement monitors, assessment templates that triggered evaluations by related disciplines, and a medical center policy for managing dysphagic patients. The team also provided training about dysphagia at nursing orientation meetings and implemented strategies that improved outcomes for dysphagic patients. The team had contributed to the following improved patient outcomes: upgrades and downgrades in diet consistency, which enhanced patient quality of life or provided increased protection from aspiration; maintenance of, or improvement in, weight and nutrition status; and a reduction in the number of patients developing aspiration pneumonia. Overall, the actions taken by the Dysphagia Team improved patient care and safety.

Opportunities for Improvement

Contracts for Special Transportation – Administration Needed Improvement

Conditions Needing Improvement. The medical center could have overpaid contract vendors as much as $167,100 for hired car and ambulance services. The Contracting Officer's Technical Representative (COTR) did not properly monitor the contracts and certified the vendors' invoices for payment without verifying that the invoices complied with contract terms.

Hired Car Services. The medical center awarded a contract for hired car services, beginning October 1, 2001, at an estimated cost of $146,000 for a 3-year period. As of July 31, 2003, the medical center had paid the vendor $284,000, which included overpayments totaling as much as $157,600. Our review of contractor invoices for June 2003 disclosed that:

- Invoices were not billed in accordance with the contract.
- Mileage was incorrectly billed to veterans' residences and then to the medical center.
- The medical center was billed the base rate of $20 twice for round-trips, when only one $20 charge was appropriate.

- The medical center was billed $70 for transporting wheelchair patients, plus $1.25 per mile, instead of the contract rates of $20 plus mileage at $1.00 per mile. The contract stated that hired vehicles must be equipped to accommodate wheelchairs.

Medical center controls were not effective to ensure that invoices were accurate and complied with the terms of the contract. The COTR responsible for certifying invoices did not have a copy of the contract, price list, or the Rand McNally Standard Mileage Guide. The COTR only randomly checked to ensure that veterans kept appointments, and did not determine whether the number of miles billed was correct and billed at contract rates. As a result, inappropriate charges totaling $4,048 of the $7,290 (55.5 percent) paid during the period of our review went unchallenged. Projecting the 55.5 percent error rate found in the June invoices reviewed to the $284,000 paid through July 2003, we estimated that the medical center overpaid the vendor as much as $157,600. Assuming the same rate of expenditure for the remaining 14 months, the medical center could save as much as $100,300 by paying contract rates for the remainder of the contract (through September 30, 2004).

We also found that some contract terms were not clearly defined. For example, miles beyond the 5-mile radius around the medical center would be charged at $1.00 per mile for round-trips, or $1.50 per mile for one-way trips. This provision is subject to misinterpretation for round-trips, because it is not clear whether "miles beyond the 5-mile radius" apply to both directions (incoming and outgoing), with the $20 base rate applicable to the 10 miles traveled within the 5-mile radius.

The OIG is conducting further review of the vendor's invoices for hired car services.

Ambulance Services. The medical center awarded a contract for ambulance services, beginning October 1, 2002, at an estimated cost of $663,608 for a 4-year period. As of July 31, 2003, the medical center had paid the vendor about $159,000. Our review of vendor invoices for June 2003 showed that the number of miles billed to the medical center exceeded the Rand McNally Standard Mileage Guide, and the vendor claimed mileage within the 5-mile base rate area. Overcharges totaling $465 of the $7,463 (6 percent) paid during the period of our review were not detected because the COTR did not review the vendor's invoices. Projecting the 6 percent error rate found in the June invoices reviewed to the $159,000 paid through July 2003, we estimated that the medical center overpaid the vendor by as much as $9,500. Assuming the same rate of expenditure for the remaining 38 months, the medical center could save as much as $36,250 by ensuring that the number of miles billed for the remainder of the contract (through September 30, 2006) is correct.

Recommended Improvement Action 1. The VISN Director should require the medical center Director to ensure that:

a. The COTR receives additional training on VA policy requiring review of vendor invoices before payments are made.
b. The Contracting Officer monitors the COTR's review process to ensure that vendors comply with contract terms and conditions.
c. The contract specifications are clarified to prevent misinterpretations.

The VISN and medical center Directors agreed with the findings and recommendations, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Needed Strengthening

Conditions Needing Improvement. During the 3-month period ending June 30, 2003, cardholders completed about 6,000 transactions totaling approximately $1.8 million. Cardholders were reconciling transactions timely; however, the following conditions needed management attention:

- The Program Coordinator was a cardholder with a spending limit of $750,000. Veterans Health Administration (VHA) policy specifies that Program Coordinators cannot be cardholders. The Program Coordinator's Government purchase card was cancelled on August 6, 2003.

- The Billing Official was also performing the duties of the Dispute Officer. VHA policy requires a separation in the duties of the Billing Official and Dispute Officer.

- Approving officials did not approve 313 transactions valued at $266,710 within 14 days, as required by VHA policy. The average age of the unapproved transactions was 58 days, ranging from 15 to 103 days.

- The Business Office did not conduct quarterly audits of cardholder accounts that were not included in the monthly statistical samples conducted by the VA Financial Service Center (FSC). VHA policy requires a quarterly review of all cardholder accounts not reviewed during the statistical samples conducted by the FSC.

Recommended Improvement Action 2. The VISN Director should require the medical center Director to ensure that:

a. The Program Coordinator is not a cardholder.
b. The duties of the Billing Official and Dispute Officer are assigned to different individuals.
c. Approving officials approve transactions within 14 days.
d. Quarterly audits are conducted of all cardholder accounts that are not included in the monthly statistical sampling audits conducted by the FSC.

The VISN and medical center Directors agreed with the findings and recommendations, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Agent Cashier – Controls Needed Improvement

Conditions Needing Improvement. The following aspects of the Agent Cashier function needed management attention:

- The Agent Cashier routinely made unescorted trips from a credit union while carrying Agent Cashier funds.
- Six of the last nine unannounced audits were not conducted within 90 days, as required by VA policy.
- The cash advance was not evaluated for adequacy during unannounced audits, as required by VA policy.
- The combination to the Agent Cashier vault was not changed following a change of incumbents in the Agent Cashier position, as required by VA policy. Medical center management had the combination to the Agent Cashier vault changed while we were onsite.

Recommended Improvement Action 3. The VISN Director should require the medical center Director to ensure that:

a. An escort is provided for the Agent Cashier during replenishment trips.
b. Unannounced audits of the Agent Cashier are conducted at least every 90 days.
c. The cash advance is evaluated for adequacy during unannounced audits.
d. The combination to the Agent Cashier vault is changed after changes of incumbents in the Agent Cashier position.

The VISN and medical center Directors agreed with the findings and recommendations, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Conflict of Interest Acknowledgments – Controls Needed Strengthening

Conditions Needing Improvement. As of August 4, 2003, none of the medical center's physicians or allied health supervisors and managers had received a copy of the VHA Conflict of Interest Rules, or signed VA Form 10-21009 NR (Conflict of Interest Acknowledgment Form). VHA policy requires that the Chief of Staff, physicians, clinicians, and allied health supervisors and managers receive a copy of the Conflict of Interest Rules and sign VA Form 10-21009 NR, which is to be maintained in their official personnel files. Medical center management began distributing the Conflict of Interest Rules to appropriate staff and obtaining signed copies of the Conflict of Interest Acknowledgement Form while we were onsite.

Recommended Improvement Action 4. The VISN Director should require the medical center Director to ensure that VHA Conflict of Interest Rules are distributed to new staff, as appropriate, and that VA Form 10-21009 NR is signed by appropriate staff and filed in their official personnel files.

The VISN and medical center Directors agreed with the findings and recommendations, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needed Improvement

Conditions Needing Improvement. The Information Security Officer (ISO) needed to improve AIS security. The following conditions needed management attention:

- The contingency plan was not comprehensive and did not meet VA policy. Specifically, the contingency plan did not: (i) document AIS hardware and software configurations; (ii) identify an alternate processing site, or the storage location for the contingency plan; and (iii) include the Winston-Salem OPC and the Charlotte CBOC.

- The medical center was using generic accounts to provide access to Veterans Health Information Systems and Technology Architecture (VISTA) for VA staff from the Health System Implementation, Training, and Enterprise Support Group. VA policy requires unique accounts with specific identifiers for each VISTA user.

- Background investigations were not conducted for six contract employees working in sensitive positions, as required by VA policy.

Recommended Improvement Action 5. The VISN Director should require the medical center Director to ensure that the ISO:

a. Develops a comprehensive contingency plan consistent with VA policy requirements.
b. Establishes unique accounts instead of generic accounts to provide access for all VISTA users.
c. Conducts background investigations for contract employees.

The VISN and medical center Directors agreed with the findings and recommendations, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Supervised Private Home Program – Medical Record Documentation and Home Inspection Follow-Up Needed Improvement

Conditions Needing Improvement. Medical record documentation and follow-up of Supervised Private Home (SPH) Program home inspections needed improvement. The SPH Program provides veterans with room, board, and general supervision in local private homes. We found no documentation that:

- VA case managers provided SPH caregivers instructions for the care of three patients at the time of admission, or following subsequent hospitalizations and clinic visits.

- The VA case manager notified a patient's physician that the patient was struck by another patient (the patient that was struck suffered no injuries), or otherwise followed up on the incident.

- The VA case manager held annual discussions, as required by Veterans Benefits Administration (VBA) policy, with the VBA field examiner to discuss the status of an incompetent veteran enrolled in the SPH program.

- VA case managers took steps to correct deficiencies noted by VA inspection team members in 3 of 10 inspection files reviewed for 2002 and 2003.

Suggested Improvement Action. The VISN Director should require the medical center Director to ensure that VA case managers:

a. Provide SPH caregivers instructions for patient care at the time of admission, or following hospitalizations and clinics visits; and document the medical records accordingly.
b. Follow up on and document all SPH incidents.
c. Document annual discussions with VBA field examiners about the status of incompetent SPH veterans.
d. Ensure that deficiencies identified during inspections are corrected, and the inspection files are documented to reflect corrective actions.

The VISN and medical center Directors agreed with the findings and suggestions, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans.

Quality Management – Documentation of Complete Action Plan Processes Needed Improvement

Conditions Needing Improvement. QM managers and responsible clinicians did not document complete action plans, as required by the Joint Commission on Accreditation of Healthcare Organizations and VHA. A complete action plan should include: (i) identification of corrective actions and outcome measures; (ii) time frames for implementation of corrective actions; (iii)

assignment of responsibility to implement corrective actions; (iv) follow-up to determine the effectiveness of the steps taken; and (v) communication of results to the appropriate committee or governing body. Two of five Medical Staff Monitors for the second and third quarters FY 2003, and two of five Root Cause Analyses (RCA) from FY 2002 did not contain documentation of complete action plan processes. For example:

- The Operative and Invasive Review Committee meeting minutes dated February 13, 2003, and April 30, 2003, did not document whether the action plan for incomplete excisions was effective.

- The June 18, 2003, Critical Care Committee meeting minutes did not document follow-up on crash cart and oxygen tank deficiencies noted during two cardio-pulmonary resuscitation codes in the Eye Clinic in April and May 2003.

- The effectiveness of corrective actions for two RCAs was not fully documented.

Suggested Improvement Action. The VISN Director should require the medical center Director to ensure that QM and program managers:

a. Document complete action plan processes, including their effectiveness in meeting goals.
b. Communicate outcomes to responsible managers or committees.

The VISN and medical center Directors agreed with the findings and suggestions, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans.

Appendix B

VISN 6 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 19, 2003

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subject: Response to OIG Combined Assessment Program Review Report—W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

To: Director, Management Review and Administration Service (105E)

1. As requested the attached subject report is forwarded for your review and further action. I have read the recommendations of the OIG, and responses to them from the Director, VA Medical Center Salisbury, and concur with both.

2. If you have any questions or require a paper-copy of the report, please contact Timothy May, Director, VAMC Salisbury, via MS Exchange or at 704-638-3346.

Daniel F. Hoffmann, FACHE

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Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 15, 2003

From: Medical Center Director (00), Salisbury VA Medical Center

Subject: Response to OIG Combined Assessment Program Review Report – W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

To: Director, Management Review and Administration Service (105E)

Attached is the W.G. (Bill) Hefner VA Medical Center's response to the August 28, 2003 draft report of the Combined Assessment Program Review conducted in August 2003.

/s/ Timothy May
TIMOTHY MAY, FACHE

Attachment

Appendix B

The following Medical Center Director comments are submitted in response to the issues discussed in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action 1. The VISN Director should require the Medical Center Director to ensure that:

a. The COTR receives additional training on VA policy requiring review of vendor invoices before payment is made.
b. The Contracting Officer monitors the COTR's review process to ensure that vendors comply with contract terms and conditions.
c. The contract specifications are clarified to prevent misinterpretations.

Concur **Target Completion Date**: See itemized listing below.

a. The following training activities have been initiated:

1) A hyperlink to the Federal Acquisition Institutes Website containing an online COTR course has been provided to the VA Medical Center staff. Staff will complete the online COTR course. http://www.faionline.com/kc/login/login.asp?kc_ident=kc0001 **Target Date: October 1, 2003**

2) The Employee Education System and VISN 6 will be jointly sponsoring COTR Training in Durham, Hampton, and a site to be selected in FY04. Salisbury staff will attend training during FY04 first quarter. **Target Date: December 31, 2003**

3) Contracting Officers, upon appointment of a COTR, will provide a briefing on duties, responsibilities and expectations. A record of such shall be included in the contract folder. The Contracting Officer will provide such briefing to the new COTR for the "Hired Car" contract, who was appointed on August 11, 2003. In addition, the Contracting Officer will conduct a review of duties, responsibilities and expectations with the existing COTR of the Ambulance contract.
Target Date: October 1, 2003

b. Monthly or quarterly meetings, as appropriate, will be conducted to ensure that the COTR is performing duties as assigned and that the Contractor is complying with the requirements of the contract. Discrepancies to be reported to the VISN 6 Contract Coordinator for appropriate action.
Target Date: October 1, 2003

c. Contracting Officers will amend or re-solicit contracts to include quality control monitors. The Ambulance contract will be amended by September 30, 2003. **Target Date: September 30, 2003** The new contract for Hired Car will be in place by December 31, 2003. **Target Date: December 31, 2003**

Recommended Improvement Action 2. The VISN Director should require the Medical Center Director to ensure that:

a. The Program Coordinator is not a cardholder.
b. The duties of the Billing Official and Dispute Officer are assigned to different individuals.
c. Approving officials approve transactions within 14 days.
d. Quarterly audits are conducted of all cardholder accounts that are not included in the monthly statistical sampling audits conducted by the FSC.

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Concur **Target Completion Date**: See itemized listing below.

a. All purchase cards held by the Program Coordinator have been cancelled to eliminate conflict of interest. **Completion Date: August 6, 2003**

b. The duties of the Billing Official and Dispute Officer have been assigned to different individuals. Crystal Barker, Purchase Card Coordinator, is the Dispute Officer and Robert Niekras, Accounting Coordinator, is the Billing Officer. Each person received his/her individual memorandum. **Completion Date: September 15, 2003**

c. All transactions will be approved within 14 days as required by the VHA directive.

1) Training of all cardholders according to VHA Directive 1730 will be conducted. **Target Date: December 31, 2003**

2) Approval actions will be monitored on a monthly basis by the Dispute Officer and the Billing Officer and reported to the Chief, Resource Management for appropriate action. **Target Date: Initiated September 1, 2003**

d. All cardholder accounts that are not included in the monthly statistical samples conducted by the VA Financial Service Center (FSC) will be audited quarterly by the Dispute Officer and the Billing Officer. Results will be reported to the Chief, Resource Management. **Target Date: Quarterly audits initiated September 9, 2003**

Recommended Improvement Action 3. The VISN Director should require the Medical Center Director to ensure that:

a. An escort is provided for the Agent Cashier during replenishment trips.
b. Unannounced audits of the Agent Cashier are conducted at least every 90 days.
c. The cash advance is evaluated for adequacy during unannounced audits.
d. The combination to the agent cashier vault is changed after changes of incumbents in the Agent Cashier position.

Concur **Target Completion Date**: See itemized listing below.

a. A procedural change was made whereby the agent cashier is required to contact the VA Police for an escort to the credit union during replenishment trips. **Target Date: Initiated August 11, 2003**

b. The Office of Associate Director to maintain a schedule of the random unannounced agent cashier audits. The Associate Director will monitor compliance of completion within the 90-day time limit. Last quarterly audit completed July 22, 2003. **Target Date: Initiated September 11, 2003**

c. The cash advance was evaluated for adequacy on August 14, 2003. At that time it was determined that $3,000 could be returned. Evaluating the adequacy of the cash advance has been added to the quarterly agent cashier audit. Last quarterly audit completed July 22, 2003. **Target Date: Next quarterly audit**

d. The combination to the agent cashier vault has been changed. Process for change of combination to the vault described in Agent Cashier Handbook located in the Agent Cashier Office. **Target Date: Completed August 6, 2003**

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Recommended Improvement Action 4. The VISN Director should require the Medical Center Director to ensure that VHA Conflict of Interest Rules are distributed to new staff, as appropriate, and the VA Form 10-21009 NR is signed by appropriate staff and filed in their official personnel files.

Concur **Target Completion Date**: See itemized listing below.

1) All current physicians and allied health supervisors and managers have signed a Conflict of Interest Acknowledgment Form that has been placed in their Official Personnel File (OPF).
Target Date: Completed August 11, 2003

2) The plan of action for continued implementation is to include this information during the New Employee Orientation process. HRMS will also attach the acknowledgment form and a copy of the VHA Directive with every internal Merit Promotion Certificate issued for every employee being considered for a physician and allied health supervisor and manager position. Upon receipt of the selection for these positions, HRMS will ensure that a completed form is obtained and filed in the employee's OPF. HRMS will monitor compliance and report quarterly at the Associate Director's Staff Meeting.
Target Date: Initiated August 11, 2003

Recommended Improvement Action 5. The VISN Director should require the Medical Center Director to ensure that the ISO:

a. Develops a comprehensive contingency plan consistent with VA policy requirements.
b. Establishes unique instead of generic accounts to provide access for all VISTA users.
c. Conducts background investigations for contract employees.

Concur **Target Completion Date**: See itemized listing below.

a. A comprehensive contingency plan consistent with VA policy requirements has been completed which includes the following:
1) AIS hardware and software configurations **Target Date: Completed August 6, 2003**

2) Identification of an alternate processing site
a) Alternate computer site for the VistA system is the PBX room in Building 5
b) Alternate computer site for the Local Area Network system is the PBX room in Building 5
c) Alternate computer site for the Exchange system is the PBX room in Building 5
d) Alternate site for the PBX room is the computer room in Building 2 Room 2025
Target Date: Completed August 6, 2003

3) Winston-Salem OPC and Charlotte CBOC **Target Date: Completed August 7, 2003**

b. VAMC Salisbury no longer allows creation of any "guest" or "generic" account for use by remote IT Specialists (Field Office staff). Each remote Field Office support team member must have an account established in her/her name on the Salisbury system as the need/support request presents. An Information Resource Management Standard Operating Procedure (SOP #6) has been developed to describe the process for these accounts. **Target Date: Completed August 8, 2003**

c. A supplemental agreement has been added to the Tarheel contract requiring background checks of employees. Background investigations were requested on July 14, 2003. All contracted employees who have access to IT systems at this medical center will be required to have background investigations as outlined in the Information Letter 90-01-6 dated July 16, 2001. The Contract Specialist consults with the ISO for determination of the need to conduct background investigations for contracted employees who have access to the IT system. **Target Date: Initiated August 2001**

Appendix B

OIG Suggestions

Suggested Improvement Action 1: The VISN Director should require the Medical Center Director to ensure that VA case managers:

a. Provide SPH caregivers instructions for patient care at the time of admission, or following hospitalizations and clinics visits; and document the medical record accordingly.

b. Follow-up and document all SPH incidents.

c. Document annual discussions with VBA field examiners about the status of incompetent SPH veterans.

d. Assure that deficiencies identified during inspections are corrected, and the inspection files are documented to reflect corrective actions.

Concur

Suggested Improvement Action 2: The VISN Director should require the Medical Center Director to ensure that QM and program managers:

a. Document complete action plan processes, including their effectiveness in meeting goals.

b. Communicate outcomes to responsible managers or committees.

Concur

Monetary Benefits in Accordance with IG Act Amendments

Recommendation 1: Better use of funds by ensuring that contract vendors providing special transportation are paid at contract rates and the number of miles billed is correct.

Better Use of Funds: $136,550

Concur

Appendix C

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

Recommendation	Explanation of Benefit	Better Use of Funds
1	Better use of funds by ensuring that contract vendors providing hired car and ambulance services are paid at contract rates and the number of miles billed is correct.	$136,550
	Total	$136,550

Appendix D

Report Distribution

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Congressman Robin Hayes
Congressman Walter B. Jones
Congressman Mike McIntyre
Congressman Brad Miller
Congresswoman Sue Myrick
Congressman David E. Price
Congressman Charles Taylor
Congressman Melvin L. Watt

Appendix D

Congressional Committees (Chairmen and Ranking Members):

Committee on Governmental Affairs, U.S. Senate
Committee on Veterans' Affairs, U.S. Senate
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
Committee on Governmental Reform, U.S. House of Representatives
Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

This report will be available in the near future on the VA OIG 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.