
# Department of Veterans Affairs
# Office of Inspector General

# Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities

## October 2002 through September 2003

Report No. 04-00625-38

December 8, 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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**Appendixes**

**Department of Veterans Affairs**
**Office Inspector General**
**Washington, DC 20420**

**Memorandum to:**

**Secretary (00)**
**Under Secretary for Health (10)**

**Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through September 2003**

1. This report summarizes recommendations and suggestions made in reports of Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews at the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities published during the period October 2002 through September 2003. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls.

2. During the period covered by this summary report, the OIG published 34 reports for CAP reviews conducted at VHA medical facilities. Each of the issues highlighted in this report resulted from identifying conditions at two or more medical facilities. We also provided fraud and integrity awareness training for about 7,300 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. The Under Secretary for Health should ensure that all Veteran Integrated Service Network and medical facility Directors are advised of the issues identified in this summary report. We may follow up on the issues reported here in future CAP reviews and include new areas of inquiry.

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

# Introduction

## Background

During the period October 2002 through September 2003, the OIG published 34 reports for CAP reviews conducted at VHA medical facilities.

## Scope of CAP Reviews

The scope of our CAP reviews is tailored to address both national and facility specific issues. Because the scope of review has been modified through time, the areas of inquiry described below were not necessarily reviewed at each medical facility included in this report. This report summarizes issues, reported in two or more CAP reports, for which recommendations or suggestions were made.

Fraud and integrity awareness briefings were also conducted during each of the 34 CAP reviews and about 7,300 VHA employees attended the briefings. The briefings included a film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and provided for question and answer sessions.

# CAP Reports Issued

| Report | VISN | Report Number | Issue Date |
|---|---|---|---|
| Combined Assessment Program Review, VA Medical Center Lexington, KY | 9 | 02-01933-3 | 10/16/02 |
| Combined Assessment Program Review, VA Medical Center Bronx, NY | 3 | 02-01760-6 | 10/18/02 |
| Combined Assessment Program Review, VA Medical Center San Juan, PR | 8 | 02-00868-15 | 11/13/02 |
| Combined Assessment Program Review, VA Medical Center Boise, ID | 20 | 02-02582-36 | 12/20/02 |
| Combined Assessment Program Review, VA Medical Center Birmingham, AL | 7 | 02-01432-39 | 12/24/02 |
| Combined Assessment Program Review, VA Northern Arizona Health Care System Prescott, AZ | 18 | 01-02641-40 | 12/26/02 |
| Combined Assessment Program Review, Chalmers P. Wylie VA Outpatient Clinic Columbus, OH | 10 | 02-01430-50 | 01/23/03 |
| Combined Assessment Program Review, VA Medical Center West Palm Beach, FL | 8 | 02-01273-55 | 02/03/03 |
| Combined Assessment Program Review, VA Medical Center Atlanta, GA | 7 | 02-02757-63 | 02/25/03 |
| Combined Assessment Program Review, VA Salt Lake City Health Care System, UT | 19 | 02-03263-68 | 03/07/03 |
| Combined Assessment Program Review, VA Medical Center Alexandria, LA | 16 | 02-01985-77 | 03/26/03 |
| Combined Assessment Program Review, VA Medical Center Huntington, WV | 9 | 02-02939-82 | 04/15/03 |
| Combined Assessment Program Review, VA Roseburg Healthcare System, OR | 20 | 03-00699-83 | 04/22/03 |
| Combined Assessment Program Review, VA Medical Center North Chicago, IL | 12 | 02-02171-89 | 04/30/03 |
| Combined Assessment Program Review, VA Medical Center San Francisco, CA | 21 | 02-00987-96 | 05/20/03 |
| Combined Assessment Program Review, James A. Haley VA Medical Center Tampa, FL | 8 | 02-03094-101 | 05/22/03 |

| Report | VISN | Report Number | Issue Date |
|---|---|---|---|
| Combined Assessment Program Review, VA Medical Center Marion, IL | 15 | 03-00760-102 | 05/27/03 |
| Combined Assessment Program Review, VA Medical Center Houston, TX | 16 | 03-01379-115 | 06/19/03 |
| Combined Assessment Program Review, VA Medical Center Iron Mountain, MI | 12 | 03-01387-126 | 07/14/03 |
| Combined Assessment Program Review, VA Medical Center Washington, DC | 5 | 02-02172-129 | 07/14/03 |
| Combined Assessment Program Review, Overton Brooks VA Medical Center Shreveport, LA | 16 | 03-01396-131 | 07/17/03 |
| Combined Assessment Program Review, VA Sierra Nevada Healthcare System Reno, NV | 21 | 03-00988-135 | 07/18/03 |
| Combined Assessment Program Review, VA Medical Center Bay Pines, FL | 8 | 03-00700-141 | 07/29/03 |
| Combined Assessment Program Review, VA Medical Center Augusta, GA | 7 | 03-00752-143 | 07/31/03 |
| Combined Assessment Program Review, Edith Norse Rogers Memorial VA Hospital Bedford, MA | 1 | 03-00821-141 | 07/31/03 |
| Combined Assessment Program Review, VA Medical Center New Orleans, LA | 16 | 02-03264-148 | 08/07/03 |
| Combined Assessment Program Review, VA Medical Center Asheville, NC | 6 | 03-01404-161 | 08/14/03 |
| Combined Assessment Program Review, Jonathan W. Wainwright Memorial VA Medical Center Walla Walla, WA | 20 | 03-01289-167 | 08/21/03 |
| Combined Assessment Program Review, VA Medical Center Butler, PA | 4 | 02-03214-163 | 08/21/03 |
| Combined Assessment Program Review, VA Illiana Healthcare System Danville, IL | 11 | 03-00987-172 | 08/26/03 |
| Combined Assessment Program Review, VA Hudson Valley Healthcare System Montrose, NY | 3 | 03-01144-170 | 08/26/03 |
| Combined Assessment Program Review, Clement J. Zablocki VA Medical Center Milwaukee, WI | 12 | 03-00445-173 | 08/29/03 |
| Combined Assessment Program Review, VA Medical Center Iowa City, IA | 23 | 03-01550-181 | 09/25/03 |
| Combined Assessment Program Review, VA Medical Center Fayetteville, AR | 16 | 03-01855-179 | 09/30/03 |

# CAP Findings by VISN and by Medical Facility

| Veterans Integrated Service Networks (VISNs) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 3 | | 4 | 5 | 6 | 7 | | | 8 | | | | 9 | | 10 | 11 | 12 | | | 15 | 16 | | | | | 18 | 19 | 20 | | | 21 | | 23 |
| CAP Review Areas | VA Hospital Bedford, MA | VA Medical Center (VAMC) Bronx, NY | VA Hudson Valley Healthcare System (HCS) Montrose, NY | VAMC Butler, PA | VAMC Washington, DC | VAMC Asheville, NC | VAMC Birmingham, AL | VAMC Atlanta, GA | VAMC Augusta, GA | VAMC San Juan, PR | VAMC West Palm Beach, FL | VAMC Tampa, FL | VAMC Bay Pines, FL | VAMC Lexington, KY | VAMC Huntington, WV | VA Outpatient Clinic Columbus, OH | VA Illiana HCS Danville, IL | VAMC North Chicago, IL | VAMC Iron Mountain, MI | VAMC Milwaukee, MI | VAMC Marion, IL | VAMC Alexandria, LA | VAMC Houston, TX | VAMC Shreveport, LA | VAMC New Orleans, LA | VAMC Fayetteville, AR | VA Northern Arizona HCS Prescott, AZ | VA Salt Lake City HCS, UT | VAMC Boise, ID | VA Roseburg HCS, OR | VAMC Walla Walla, WA | VAMC San Francisco, CA | VA Sierra Nevada HCS Reno, NV | VAMC Iowa City, IA |
| Accounts Receivables | ● | | | ● | ● | | | | | | | | | | | | | ■ | | ■ | | | ■ | | | | | ■ | | ■ | ■ | | | ● |
| Clinical Laboratory Security | ■ | | | | | ■ | | | | | | | ■ | | | | ■ | | ■ | ■ | ■ | | ● | ● | ■ | ● | | ■ | | ■ | ■ | | ■ | ■ |
| Community-Based Outpatient Clinics | ● | | | ■ | | | | | | | | | ■ | | ■ | | | | | ● | | | ■ | ■ | | | | ■ | | ■ | | ● | | |
| Community Residential Care | | | | | | | | ● | | | | | | | | | | | | | | ● | ■ | | | | | ■ | | ■ | ● | | | |
| Contracting for Clinical Services and Sharing Agreements | | ● | | ● | ● | | ● | ● | | ● | ● | ■ | | ● | ● | ● | | ● | | | ■ | ■ | ■ | | | | ● | ■ | ■ | ■ | | ● | ● | ■ |
| Contracting for Non-Clinical Services | | ● | ● | ● | | | ● | ● | ● | ● | ● | ● | | | ■ | ■ | ● | ■ | | | ■ | ■ | ● | ● | ● | | ■ | ■ | | | ● | | | ■ |
| Controlled Substances Accountability | ● | ● | | ● | ● | ● | ● | ● | ● | ● | ● | | ● | ● | ● | ● | ● | ● | ■ | ● | ● | | ● | ● | ● | ● | ● | | ● | ● | | ● | | ● |
| Environment of Care | ● | ● | ● | ● | ● | ● | | ● | ● | | | ● | ● | ● | | ● | ● | ● | | ● | ● | | ■ | ● | ● | | | ● | ■ | ● | ● | | | ● |
| General Post Funds | | | | | | | | | | | | | | ● | | | | | | | | | ■ | | | | | | ● | | | | | |
| Government Purchase Cards | ● | ● | ● | ● | ● | ● | ● | ■ | ● | ● | ● | ● | ● | ● | ■ | ● | | ● | ● | | ● | ■ | ● | ● | ● | ■ | ● | ■ | ■ | ● | ■ | ● | ● | ■ |
| Homemaker/Home Health Aide Program | | | | | | | ● | ■ | | ● | ● | ■ | | ● | ● | ● | | | | | | ● | | | | | ● | | ● | | | ● | | |
| Information Management Security | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ■ | ● | ● | ● | ● | ● | ● | ■ | ● |
| Management of Equipment Inventories | ● | | | | | | | | | | | | | ● | | | | | | | | | ● | | | ■ | | ■ | ● | ● | | | | |
| Management of Supply Inventories | | | ● | | ● | | ● | | | ● | | | | ● | | ● | ● | ■ | ■ | ● | ■ | ● | ● | | | ● | ● | ■ | ● | ● | ● | | ● | ■ |
| Management of Violent Patients | ● | | ● | ● | | | | | ● | | | | | | | | ● | ● | | ● | ● | | ● | | ● | | | | | | ● | | ● | ■ |
| Medical Care Collections Fund | ● | | ■ | | | | | | | | | | | | | | ● | | | ● | ■ | | ● | | | ■ | | | | ● | ■ | | | ● |
| Patient Care and Quality Management | ■ | ● | | ● | ■ | ● | ● | ● | | ● | ■ | ● | ■ | ■ | ■ | ● | ● | ■ | ● | | ■ | ● | ■ | ● | | ■ | ● | ● | ● | ● | ● | ● | ● | ● |
| Patient Waiting Time | | | | | | ■ | | | ● | | | ■ | ■ | | ● | | ■ | ■ | ● | | | | | | ● | ■ | | | | | | ■ | ■ | | |
| Pharmacy Waiting Time, Security, and Prescription Refills | | | | ● | | | | ● | ● | ● | | ● | | ■ | ■ | ● | | | ■ | | | | ■ | ■ | | | ● | | ■ | ■ | ● | ● | | ■ |
| Prosthetics | | | | | | | ● | ● | | ● | | | | ■ | | | | | | | | ● | | | | | | | ● | | | | | |
| Time and Attendance of Part-Time Physicians | | ● | | | ■ | | ● | ● | | ● | ● | ● | | ● | ■ | ■ | | ● | | | | ■ | | ■ | | | ■ | | ■ | | | ■ | | ● |
| Vendor Visits/Gratuities | | ● | | | ■ | | ● | | | | | | | ■ | ■ | ■ | | ■ | | | | | | | | | ■ | ■ | ● | | | | | |

SHADED = AREA REVIEWED AT THIS SITE
● = IMPROVEMENT NEEDED AT THIS SITE

# Summary of CAP Findings

## 1. Accounts Receivables (findings at 4 of 11 medical facilities)

- Establish procedures to bill and collect all outstanding Federal accounts receivable.
- Pursue delinquent debts more aggressively.
- Require telephone contacts with insurers when third notices are sent.
- Improve collection efforts by initiating timely billing for inpatient care and by aggressively pursuing former employees' debts.

## 2. Clinical Laboratory Security (findings at 3 of 16 medical facilities)

- Restrict access to the clinical laboratory area.
- Restrict traffic between the blood draw room and the laboratory and institute sign-in procedures in the clinical laboratory.

## 3. Community-Based Outpatient Clinics (findings at 3 of 10 medical facilities)

- Require Ambulatory Care staff to review the Primary Care Management Module database monthly and remove inactive patients.
- Require password-protected screensavers be used on all community-based outpatient clinic computers.

## 4. Community Residential Care (findings at 3 of 6 medical facilities)

- Ensure VA clinicians visit patients every 30 days as required.

- Document informed consent when patients are placed in homes that are not approved by VA.

- Provide employees with annual ethics training, including coverage of conflict of interest requirements.

## 5. Contracting for Clinical Services and Sharing Agreements (findings at 14 of 22 medical facilities)

- Pursue a more cost effective contract arrangement with universities to provide compensation and pension examinations, where applicable.

- Ensure contracting officers obtain cost data to support contract and VA/Department of Defense agreements and document price negotiation memorandums in contract files.

- Ensure officials developing, soliciting, awarding, and administering contracts comply with conflict of interest requirements.

- Ensure Contracting Officer's Technical Representatives (COTRs) effectively monitor contractor performance and compliance with contract terms.

- Ensure clinical services contracts include required clauses that facilitate performance monitoring.

- Pursue recovery of overcharges in a timely manner.

- Implement controls to improve contract administration and compliance with VA procurement policies and procedures.

- Ensure network contracts for community nursing homes contain the required price negotiation memorandums and supporting documentation to justify actions such as exercising option years.

- Improve administration and negotiation of enhanced sharing agreements.

## 6. Contracting for Non-Clinical Services (findings at 14 of 22 medical facilities)

- Improve documentation of contract price determination and award decisions.
- Monitor contractor performance.
- Negotiate prices for noncompetitive contracts as required by Federal Acquisition Regulations.
- Ensure COTRs verify work performed to detect and prevent overbilling.
- Provide refresher training to COTRs and Financial Resource Section staff regarding their responsibilities.
- Require COTRs to verify transcription services prior to certifying invoices.

## 7. Controlled Substances Accountability (findings at 27 of 34 medical facilities)

- Properly schedule and conduct controlled substances inspections in all areas where these substances are stored.
- Account for unusable and expired controlled substances in monthly inspections.
- Develop and document a training program for inspectors of controlled substances.
- Complete monthly controlled substances inspections within 1 business day.
- Maintain complete accountability records for all Schedule II-V controlled substances.
- Store unusable and expired controlled substances in sealed containers in the pharmacy vault, and properly witness and document custody and destruction of these substances.
- Reduce excessive inventories of controlled substances.
- Report missing controlled substances to the OIG.

- Update facility policies to include reporting requirements regarding the loss of controlled substances and reference to current VHA policies.

## 8. Environment of Care (findings at 22 of 24 medical facilities)

- Improve pest control.
- Initiate work orders timely and complete work satisfactorily.
- Provide clean and odor-free patient care areas and public areas, including public restrooms.
- Conduct frequent random environmental rounds.
- Improve patient safety by storing potentially dangerous objects and substances out of reach of patients.
- Keep patient care and food preparation areas clean and establish deep-cleaning schedules.
- Thoroughly clean and maintain all Canteen areas.

## 9. General Post Funds (findings at 2 of 3 medical facilities)

- Obtain donation letters specifying how donations are to be used.
- Document the purpose of expenditures.
- Monitor deposits and expenditures.

## 10. Government Purchase Cards (findings at 24 of 31 medical facilities)

- Ensure acquisition personnel, including purchase cardholders, use the designated Federal Supply Schedule or national contracts before making open market purchases.

- Ensure purchase cardholders do not engage in "purchase splitting practices."[1]
- Ensure telecommunications services are not procured with purchase cards.
- Ensure purchase cardholders and approving officials reconcile and certify invoices timely.
- Conduct monthly and/or quarterly audits of purchase card transactions, as required.
- Ensure adequate separation of duties over purchase card activities.
- Provide purchase cardholders and approving officials adequate, documented training.
- Provide appropriate warrants to purchase cardholders with purchase limits in excess of $2,500 and ensure interim warrants are properly granted and used.
- Cancel purchase cards for employees routinely failing to comply with purchase card policies and procedures.

## 11. Homemaker/Home Health Aide Program (findings at 10 of 12 medical facilities

- Consider the prevailing state Medicaid rates when contracting for services.
- Complete and document interdisciplinary assessments for all patients referred to the program.
- Ensure program coordinators and billing staff coordinate when a patient is hospitalized or is no longer receiving services.
- Obtain and review quarterly performance improvement and patient assessment reports to evaluate the quality of care and need for continued service.
- Ensure clinicians reassess the need for services at 90-day intervals.
- Conduct visits or make telephone contacts with patients to assess their satisfaction with services.

[1] Purchase splitting involves separating a single purchase into two or more procurements to circumvent the purchase card dollar limit or cardholder's warrant limitation. Purchase splitting is also employed to avoid requirements for competition in the procurement of higher value goods and services.

- Ensure all bills are reconciled timely and program coordinators are notified of discrepancies between services authorized and services actually provided.
- Ensure patients receiving services meet clinical eligibility requirements.
- Complete and document initial and follow-up assessments for all patients referred to the Homemaker/Home Health Aide Program.

## 12. Information Management Security (findings at 32 of 34 medical facilities)

- Develop a consolidated and comprehensive information security contingency plan that contains all required elements.
- Ensure major information systems are certified and accredited.
- Monitor access to computer-based employee-patient records.
- Ensure the Information Security Officer is qualified, trained, and reports to the Director or Associate Director.
- Perform background investigations on Information Resources Management (IRM) Service employees.
- Periodically review authorized users' access to determine if they still have a legitimate need, and terminate their access when employment ends or they no longer have a valid business need.
- Document appropriate security clearances and sensitivity level information for key employees.
- Remind all employees to log off computers when leaving their workstations.
- Store computer back-up tapes in a secure off-site location.
- Require IRM Service employees to back-up server configurations on a computer at the back-up facility.
- Issue policy on, and monitor, remote Local Area Network usage.
- Certify that sensitive data has been removed from equipment with storage media before disposing of the equipment.

- Monitor access to the computer rooms.
- Correct physical security deficiencies in computer rooms and other information technology locations.

## 13. Management of Equipment Inventories (findings at 5 of 8 medical facilities)

- Validate and update equipment inventory lists (Consolidated Memorandum Receipts or CMR lists) annually.
- Conduct equipment inventory inspections.
- Implement procedures to correct and update inaccurate and incomplete CMR lists.

## 14. Management of Supply Inventories (findings at 17 of 21 medical facilities)

- Fully implement the Generic Inventory Package (GIP) for all inventory points.
- Improve accuracy and update GIP data.
- Provide GIP training to all inventory managers.
- Eliminate stock in excess of a 30-day supply, excluding stock maintained for emergencies.

## 15. Management of Violent Patients (findings at 12 of 13 medical facilities)

- Document analyses of violent patient incidents in committee minutes and post alerts about potentially violent patients in the Veteran Health Information System and Technology Architecture computer system.
- Assign a coordinator to oversee the Prevention and Management of Disruptive Behavior Program and ensure annual training to all employees working in high-risk areas.

- Establish an interdisciplinary committee to review violent or threatening patient incidents and make recommendations about the management of patients who display these behaviors.
- Establish processes that ensure Psychiatric Crisis Teams conduct debriefing sessions after emergency responses.
- Implement procedures for involving clinicians in violent patient incident reviews.

## 16. Medical Care Collections Fund (findings at 6 of 10 medical facilities)

- Implement procedures to obtain and update veteran insurance information at the time of treatment.
- Pursue Medical Care Collections Fund accounts receivable more aggressively.
- Eliminate the backlog of unprocessed insurance bills and initiate timely billings.

## 17. Patient Care and Quality Management (findings at 20 of 30 medical facilities)

- Ensure employees consistently follow procedures to positively identify patients.
- Consider peer review data in re-privileging decisions.
- Monitor safety and quality control.
- Document and analyze patient complaints and direct patient complaints to service chiefs or Quality Management program staff.
- Monitor all significant Quality Management action items until resolved.
- Develop procedures for the implementation and tracking of Root Cause Analysis corrective actions until issues are resolved.
- Aggregate and trend peer review outcomes.
- Analyze and use QM data to improve the quality of patient care.

- Collect and trend performance improvement data, and use the data to make patient care decisions.
- Analyze mortality data to identify patterns or trends.
- Perform better follow-up on recommendations from boards of investigations and improve documentation of resolution and follow-up of QM reviews.
- Develop and document appropriate corrective actions for Level 2 and Level 3 peer review findings.
- Ensure the Professional Standards Board reviews and documents Level 3 peer review findings.
- Improve reviews of responses to cardio-pulmonary episodes.

## 18. Patient Waiting Time (findings at 4 of 12 medical facilities)

- Include fee-basis patient appointments in determining and monitoring average waiting time.
- Ensure that patient waiting time is accurately reported.
- Improve service to patients by reducing waiting time and providing additional seating in the clinic waiting area.
- Ensure that enrollment applications are processed within 7 days of receipt and appointments for new primary care enrollees are scheduled within 180 days of the dates.

## 19. Pharmacy Waiting Time, Security, and Prescription Refills (findings at 9 of 17 medical facilities)

- Verify that the patient receives all medications before he/she leaves the dispensing window.
- Reduce waiting time for prescriptions.
- Improve the physical security of the dispensing area.

- Provide privacy hoods for security door access keypads, if applicable.
- Install a cage door for physical security of the anteroom to pharmacy vaults, if applicable.
- Ensure pharmacies have alarm systems.
- Ensure that pharmacy employees can surveil all pharmacy entrances to observe persons requiring access.
- Require refrigerated controlled substances to be stored in lockable refrigerators.

## 20. Prosthetics (findings at 5 of 6 medical facilities)

- Obtain physicians' prescriptions before issuing equipment, supplies, and accessories.
- Inventory durable medical equipment stored in contractor's warehouses and reconcile with VA records.
- Determine veterans' eligibility for eyeglasses before ordering eyeglasses from vendors.
- Properly enter data into the national prosthetics database.

## 21. Time and Attendance of Part-Time Physicians (findings at 9 of 17 medical facilities)

- Ensure physicians are present at the medical center during their tours of duty.
- Adjust surgeons' hours of work consistent with actual workload requirements.
- Cease improper payments to part-time physicians for on-call status.
- Ensure part-time physicians designate their core hours.
- Ensure timekeepers verify physicians' attendance, and conduct semi-annual audits of timekeepers' records.
- Provide required training to all timekeepers.

- Train all physicians and their supervisors on VA time and attendance policies.

## 22. Vendor Visits/Gratuities (findings at 3 of 10 medical facilities)

- Prohibit vendor representatives from visiting the medical facility without appointments.
- Discontinue allowing vendors to provide employees with meals that exceed annual dollar limitations on such gifts.

**Appendix A**

# OIG Contact

| | |
|---|---|
| **OIG Contact** | Dennis Sullivan, OIG Office of Audit Planning Division<br>Phone Number (202) 565-4685 |

**Appendix B**

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on VA, HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
General Accounting Office
Office of Management and Budget

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.