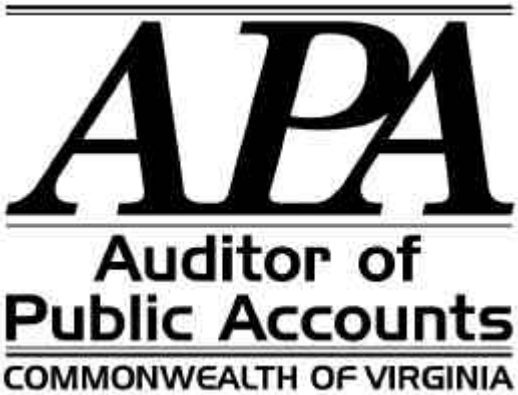
VIRGINIA DEPARTMENT OF HEALTH

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2001



AUDIT SUMMARY

Our audit of the Virginia Department of Health for the year ended June 30, 2001, found:

- Amounts reported in the Commonwealth Accounting and Reporting System were fairly stated;
- Internal control matters that we consider reportable conditions, however, we do not consider these matters to be material weaknesses;
- Instances of noncompliance with selected provisions of applicable laws and regulations; and
- Incomplete implementation of corrective action with respect to the audit findings reported in the prior year as reported.

Our audit findings include the following:

- Develop a reliable and realistic funding scheme and reassess the timeline of the Web-VISION project plan
- Improve EMS web-trauma registry project planning and project communication
- Fill critical Office of Information Management positions
- Manage contracts and update procurement policies and procedures
- Improve method of allocating local health department funding

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Commonwealth of Virginia

Walter J. Kucharski, Auditor

Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

December 4, 2001

The Honorable James S. Gilmore III
Governor of Virginia
State Capitol
Richmond, Virginia

The Honorable Vincent F. Callahan, Jr.
Chairman, Joint Legislative Audit
and Review Commission
General Assembly Building
Richmond, Virginia

INDEPENDENT AUDITOR'S REPORT

We have audited the financial records and operations of the **Virginia Department of Health** (Health) for the year ended June 30, 2001. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Audit Objectives, Scope, and Methodology

Our audit's primary objectives were to evaluate the accuracy of recording financial transactions on the Commonwealth Accounting and Reporting System, review the adequacy of Health's internal control, and test compliance with applicable laws and regulations. We also reviewed Health's corrective action of audit findings from the prior year report.

Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observations of Health's operations. We also tested transactions and performed such other auditing procedures as we considered necessary to achieve our objectives. We reviewed the overall internal accounting controls, including controls for administering compliance with applicable laws and regulations. Our review encompassed controls over the following significant cycles, classes of transactions, and account balances:

Information Systems	Payroll
Expenses	Contract Management
Grant Management	Revenues
Accounts Receivable	

We obtained an understanding of the relevant internal control components sufficient to plan the audit. We considered materiality and control risk in determining the nature and extent of our audit procedures. We performed audit tests to determine whether Health's controls were adequate, had been placed in operation, and were being followed. Our audit also included tests of compliance with provisions of applicable laws and regulations.

Health's management has responsibility for establishing and maintaining internal control and complying with applicable laws and regulations. Internal control is a process designed to provide reasonable,

but not absolute, assurance regarding the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

Our audit was more limited than would be necessary to provide assurance on internal control or to provide an opinion on overall compliance with laws and regulations. Because of inherent limitations in internal control, errors, irregularities, or noncompliance may nevertheless occur and not be detected. Also, projecting the evaluation of internal control to future periods is subject to the risk that the controls may become inadequate because of changes in conditions or that the effectiveness of the design and operation of controls may deteriorate.

Audit Conclusions

We found that Health properly stated, in all material respects, the amounts recorded and reported in the Commonwealth Accounting and Reporting System. Health records its financial transactions on the cash basis of accounting, which is a comprehensive basis of accounting other than generally accepted accounting principles. The financial information presented in this report came directly from the Commonwealth Accounting and Reporting System.

We noted certain matters involving internal controls and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal control that, in our judgment, could adversely affect Health's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial records. Reportable conditions are discussed in the sections entitled "Office Of Information Management," "Drinking Water State Revolving Fund," and "Other Control Findings and Recommendations." We believe that none of the reportable conditions are material weaknesses.

The results of our tests of compliance with applicable laws and regulations disclosed an instance of noncompliance that is required to be reported under Government Auditing Standards, which is discussed in the finding entitled "Strengthen Controls Over Binding Commitments."

Health has not completed adequate corrective action with respect to the previously reported findings entitled "Develop a Reliable and Realistic Funding Scheme and Reassess the Timeline of Project Plan," "Fill Critical Office Of Information Management Positions," "Strengthen Controls over Small Purchase Charge Card," and "Manage Contracts and Update Procurement Policies and Procedures." Accordingly, we included these findings in the sections entitled "Office Of Information Management" and "Other Internal Control Findings and Recommendations." Health has taken corrective action with respect to audit findings reported in the prior year that are not repeated in this report.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.

EXIT CONFERENCE

We discussed this report with management at an exit conference held on December 18, 2001.

AUDITOR OF PUBLIC ACCOUNTS

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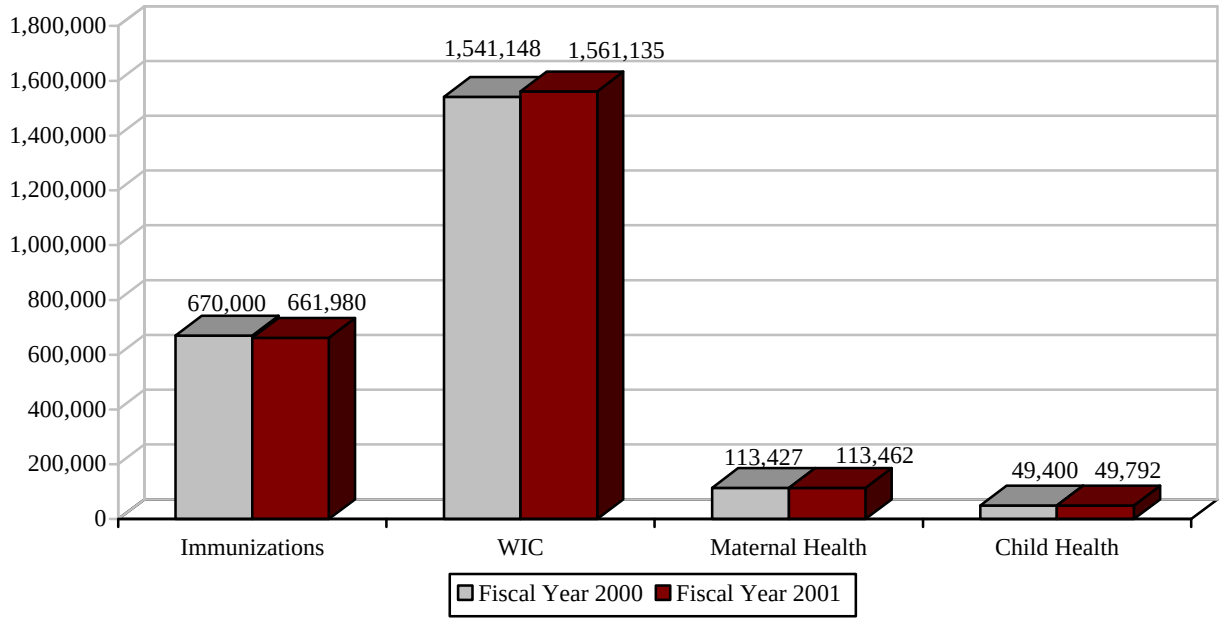
AGENCY OVERVIEW

The Virginia Department of Health seeks to achieve and maintain personal and community health by emphasizing health promotion, disease prevention, and environmental protection. Health administers the state's system of public health.

The State Board of Health, appointed by the Governor, defines its mission as "To provide leadership in planning and policy development for the Commissioner and the Virginia Department of Health to implement a coordinated, prevention-oriented program that promotes and protects the health of all Virginians. In addition, the Board serves as the primary advocate and representative of the citizens of the Commonwealth in achieving optimal health." The Board of Health is responsible for determining the services Health provides, defining income limitations for recipients for specific services, and setting fees for local health departments.

Health operates through a central office and 35 health districts that operate 119 local health departments. During fiscal year 2001, patient visits to local health departments totaled over 2.8 million. These patients received services in various areas such as the child health; maternal health; the Women, Infants, and Children (WIC) nutritional program; and immunization clinics, which are illustrated in the graph below.

Number of Patient Visits for Selected Services



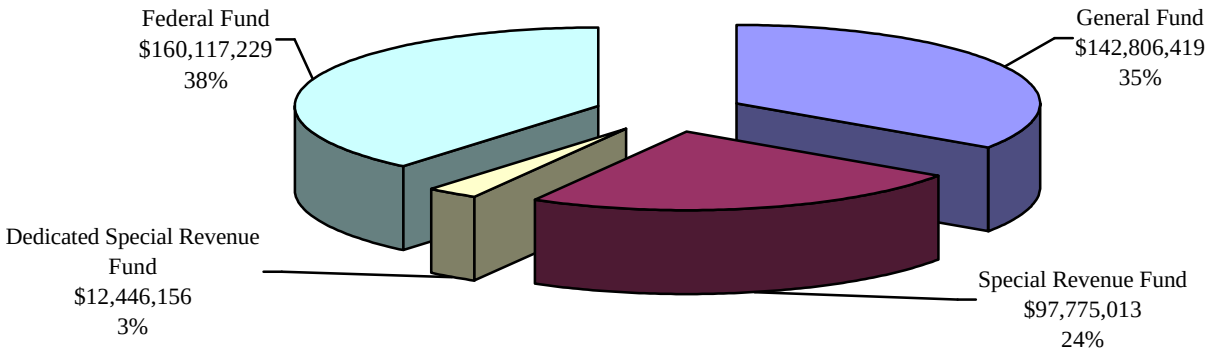
Local health departments are part of Health and operate under contracts between the state and the participating local governments defining the health services funded by the localities in the health districts. Programs offered include communicable disease control, preventative care, and health education. In addition to patient visits, local health departments are responsible for inspecting restaurants and drinking water and issuing permits for sewage systems, wells, and waterworks operations. Additionally, most local health departments provide a variety of nonmandated health care services for persons who cannot otherwise afford them.

FINANCIAL OPERATIONS

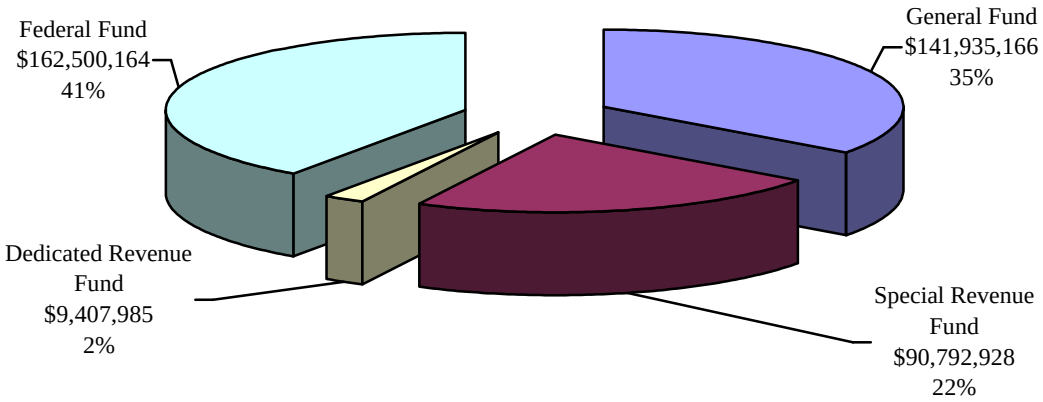
As illustrated below, Health received over $413 million in revenue during fiscal year 2001. In addition to $160.1 million in federal revenue, Health also received $3.3 million in federal pass-thru funds from other agencies, which together represent the largest funding source. The single largest source of federal revenue is the WIC program, which accounts for more than 46 percent of federal revenue and expenses. The section of this report entitled, "Nutritional Program for Women, Infants, and Children" describes this program.

The majority of Health's special revenue funding and total expenses relate to community health services. These programs enhance access to health care by administering clinical services through cooperation with various localities throughout Virginia. Each of the 119 local health departments provides services, which include child health, family planning, environmental health, and communicable disease control. The localities, through their cooperative agreements with Health, can also fund other services provided at the local health department. These agreements specify the maximum amount of funding the locality and Health will contribute to the operation; the range of services provided; the income level served; the ownership of equipment; and the responsibility for the legal defense of local health department staff.

Revenues - Fiscal Year 2001



Expenditures - Fiscal Year 2001



NUTRITIONAL PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

The WIC program provides supplemental food and nutritional education for eligible pregnant, postpartum, and breast-feeding women, as well as children up to five years of age. The WIC program serves the citizens by providing an adjunct to good health care intended to prevent the occurrence of health problems and improve the health status of participants during critical times of growth and development. Its purpose is to provide nutrition education and food assistance to citizens found to be the most vulnerable to the effects of poor nutrition and to achieve optimal nutritional status for children before entry into school. Participants receive assistance in the form of food supplements and education. Health administers the WIC program through local health departments who determine qualifying criteria for participation in the program. Health has been working to implement a new information technology application (WIC-NET) for the WIC program, but this system has incurred ongoing delays. However, in November 2001, Health implemented a pilot program, the WIC-NET system, at the Hampton health department.

OFFICE OF INFORMATION MANAGEMENT

The Office of Information Management (OIM) has made numerous efforts to improve the division's function and performance in the past year. OIM completed an information technology (IT) strategic plan to help determine and better articulate the agency's IT needs and direction. The strategic plan also initiated the creation of an annual OIM work plan, which will help determine the immediate priorities of the division. In addition, the Commissioner has hired a chief information officer (CIO) and moved steadily towards the implementation of its most complex and significant project, the web-based Virginia Information Systems – Integrated On-line Network (Web-VISION).

Although OIM has improved its performance, there are still deficiencies it must continue to address, such as the need for stronger controls over several critical systems. In addition, inadequate funding and lack of communication continues to cause delays in the implementation and management of information systems development (IS) projects. These issues continue to place OIM projects at risk of not meeting functionality or implementation objectives.

As described in our previous reports, the original VISION project had many deficiencies. Late in 1999, management decided that the recently implemented VISION system was obsolete, the data in the system was corrupt, and the system no longer met Health's functionality needs. Therefore, management decided to create the new Web-VISION by rewriting the VISION system into an internet-based application and restoring the integrity of the data. Web-VISION will be a patient-level system that manages client registration, patient visit documentation, immunizations, accounts receivable, community events, and maternity statistics.

The initial projected implementation date for Web-VISION was January 2001. Due to unanticipated accounts receivable module problems in fiscal year 2000, the implementation date was postponed to April 2002, 15 months later. Currently, the project team has completed the majority of the Web-VISION development, users are testing the application, and the project team is reviewing security. "Cleaning up" data is a time-consuming issue and implementation of the project will not occur until the project team can restore all data integrity. The implementation date is currently May 2002, but the project team anticipates further delays due to data conversion issues.

The previous items affect several of the detailed issues set out within this report. How management addresses these issues will affect the future direction of Health's information technology efforts.

Develop a Reliable and Realistic Funding Scheme and Reassess the Timeline of the Web-VISION Project Plan

Management does not have a realistic and reliable funding scheme for Web-VISION. Plans include requesting and receiving additional appropriations and shifting resources from other nonservice areas to this project. However, the plan does not identify these nonservice areas, nor is management's response to reduced funding in any nonservice areas included. In addition, cleaning up and transferring data from the current system into Web-VISION continues to be a time-consuming issue, causing the probability of further implementation delays.

The Governor proposed a $2.9 million amendment for technology costs to Health's general fund appropriation in the 2001 budget bill; however, with no approved amendments, Health did not obtain additional funding. At this time, it is unlikely that the General Assembly will be able to add additional funding in the 2000-2002 state budget when it convenes for the 2002 Session.

Without additional appropriations, management's plan is to internally shift resources from other nonservice areas to this project. A detailed plan outlining these funding shifts and corresponding changes in the other service areas is necessary to verify that funding will be available and to ensure that Health will continue essential operations. This plan will also assist management in determining whether they should adopt a more realistic timeframe and schedule for implementing Web-VISION.

With most of the system development of Web-VISION complete, the project is quickly approaching the implementation date. However, implementation cannot occur without the completion of data transfer and clean up from the current systems. The data transfer and clean up phase is over five months behind schedule and the team is continuing to find additional problems. Management must revise the implementation plan to provide current guidance to establish timeframes and resource needs if Health hopes to successfully complete the project.

Management should determine and identify available funding sources and plan the Web-VISION implementation accordingly. In addition, management should adjust the plan to include anticipated delays, therefore establishing an accurate plan with the necessary resources.

Improve EMS Web-Trauma Registry Project Planning and Project Communication

Lack of project management and communication between OIM and Emergency Medical Services (EMS) continues to cause implementation delays and increase project costs. OIM is developing and implementing the new web-based Trauma Registry system for use by EMS. The two divisions are not communicating effectively, which prevents them from understanding each other's needs. In fiscal year 1999, the estimated cost of the project was $110,000. Current estimates of the total project costs are nearly $700,000 and management does not have a complete and current project plan and budget.

The success of a project is dependent on effective communication. Meetings between OIM and EMS do not occur frequently enough and the reports used to communicate the project status and resolve technical issues are ineffective. Without improved communication, the project could ultimately fail to meet the needs and requirements of the users while costs continue to rise.

Without a complete and current project plan, management cannot monitor the progress and success of the project. A current project plan should outline the original and current estimate of time and funding needed for successful implementation. The plan should include milestones and reasonable end dates, in addition to all resources needed to complete the project.

The Health Commissioner should direct the project team to establish an accurate project plan that is understandable and agreeable to both OIM and EMS. The plan should accurately reflect the necessary resources and time needed to successfully complete the project. In addition, the Health Commissioner should periodically review the progress of the Web-Trauma Registry project.

Fill Critical Office of Information Management Positions

Health has temporary assigned staff to fill several key information technology management positions. In addition, Health employees holding other positions also fill some of the vacant positions in acting roles. These temporary assigned staff fill the critical positions of Agency Security Officer, OIM Site Security Officer, Configuration Manager, and Database Administrator within OIM.

The Acting Agency Security Manager and the OIM Site Security Officer hold an additional full time position elsewhere within Health. Although these employees have experience and dedication, they cannot spend sufficient time to effectively perform their duties for both positions. Health should budget for and permanently fill essential information technology management positions.

Assign Responsibility for Security of the ORACLE Production Databases and Develop Policies and Procedures or Guidelines for Maintaining Proper Controls

There are no policies or procedures regarding how to grant access to the oracle databases or who is responsible for reviewing or monitoring access logs. Failure to provide proper auditing of the databases could result in unauthorized access to the databases going undetected. In addition, Health has not identified critical areas that should be subject to audit and review; however, it is working to determine what would be the most critical areas to monitor for each individual system running on the ORACLE production databases.

Health does not have anyone assigned to the security of the production database; therefore, no one is keeping track of monitoring, auditing, and other controls that need to be in place for systems in production residing on the ORACLE production databases. In addition, Health could not identify users with administrative privileges. Our review also identified an unchanged default password, which could lead to unauthorized access to the databases.

We recommend that Health obtain a data base administrator with full responsibility for maintaining security controls over the ORACLE production databases. We also recommend that Health complete its plans to review the use of the database audit function and other audit tools. Management should determine what is best for their business purposes and develop a comprehensive policy and/or procedure for maintaining critical systems residing on the ORACLE databases.

Strengthen Operating System Security Policies

The Office of Information Management does not have standard UNIX policies that cover periodic review of file permissions, implementing vendor security features, and granting of access to users who can make major changes to the UNIX files. The lack of these policies could lead to inappropriate access to critical data and programs. Once accessed, an individual could either accidentally or maliciously alter and seriously compromise operations.

The Department uses client server architecture for its financial and vital records systems. The underlying operating system for these servers is UNIX. Security of any computer system is comprised of two layers. The application layer generally provides control via menu options or screen presentations of what users can do within a program. The operating system layer security generally provides controls of who can access the system at the file level and add or delete files.

We recommend the Office of Information Management significantly enhance the current policies and procedures for UNIX and follow these procedures for maintaining security of the UNIX system. These policies should include a periodic review to ensure that all critical files have appropriate access permissions and not all staff can access these files. Strengthening file access policies will improve security over important operating system and data files. Policies also provide continuity of secure operations as personnel change over time.

DRINKING WATER STATE REVOLVING FUND

The federal Safe Water Act of Amendments of 1996 established a Drinking Water State Revolving Fund (Drinking Water Fund) Program where eligible states receive funds through a capitalization grant. Virginia received it first federal fund award for the Drinking Water Fund in 1997. The Drinking Water Fund provides assistance to qualified communities, local agencies, and private entities to ensure compliance with provisions of the federal Safe Drinking Water Act. Health's Office of Water Programs administers the Drinking Water Fund by funding projects that ensure the waterworks' long-term capacity to produce safe drinking water and to protect construction loan investments. Health also provides technical and financial assistance to waterworks owners. Since inception of the program, Health closed loans on 48 projects of which 20 project loan closings totaling $24.6 million occurred during fiscal year 2001. Health anticipates closing an additional 34 loans totaling $40.3 million during the next fiscal year.

Strengthen Controls over Binding Commitments

Health did not enter into binding commitments for 18 percent of the loans scheduled within the required one-year time frame. Health had cumulative receipts of $63,251,467, but only committed $51,699,298. Federal regulations require Health to enter into cumulative binding commitments within one year in an amount equal to the amount of each grant payment plus the required state match in accordance with Code of Federal Regulations (CFR) Section 40.34 (e).

Loan closing dates are tentative and binding commitments use these tentative dates. The borrowers and grant recipients do not always know of the many items needed and procedures required to have a loan closed properly. This lack of knowledge delays loan closings, which can result in noncompliance with federal regulations and the loss of federal funding.

We recommend Health educate borrowers and grant recipients on the policies and procedures necessary to have a successful loan closing. In addition, Health should review the current methodology of determining loan closing dates, so that Health can more accurately comply with the federal binding commitment regulation.

OTHER INTERNAL CONTROL FINDINGS AND RECOMMENDATIONS

Strengthen Controls Over Small Purchase Charge Cards

Health needs to comply with its procedures over the small purchase charge card program (SPCC). Health has issued charge cards to approximately 200 staff for purchasing various goods and services, which resulted in purchases over $2.8 million, an increase of 33 percent from last year. Health has developed policies and procedures for the program to ensure that all purchases made using the SPCC are appropriate and charges are accurate. However, we found specific internal control weaknesses where staff were not following the procedures.

Without the statement review and approval and its reconciliation process, unauthorized purchases will go undetected. In addition, Health cannot assure that its charges are correct. This lack of internal control could lead to fraudulent charges and incorrect payments.

In response to prior year's management recommendation, management updated their policy and procedure manual, including a standardized purchasing log; and implementing a training program to ensure the training of all current and new cardholders.

Health should enforce compliance with its procedures over the charge card payment and reconciliation process and should consider revoking charge cards from cardholders who violate policies and procedures. Management should reissue cards to employees authorized to make purchases and discontinue the practice of card sharing. Strengthening the internal controls over the SPCC Program will reduce the risk of fraudulent charges and ensure purchases are proper.

Manage Contracts and Update Procurement Policies and Procedures

Health spent $74 million during this fiscal year for contractual services representing 17 percent of total expenses and has begun providing contract management guidance; which includes guidance on maintaining a list of contracts. However, there is no required process to track contracts with pertinent information such as contract number, contract officer, contract administrator, or the start and end dates of the contract. Health encourages, but does not require, all work units to maintain a list of their contracts. In addition, Health has not developed its own contract management procedures that include important information such as Health's unique decentralized contracting processes.

We found several instances where Health was paying for services under the terms of expired contracts and without a proper contract or agreement in place. We also found situations where employees exceeded their delegated purchasing authority. In addition, work units were unfamiliar with contract administration responsibilities and did not identify contract administrators for their contracts. Contract files should contain a designated contract administrator whose responsibility is to ensure compliance with contract requirements to help ensure Health receives the contracted services or goods. It is imperative that the employees in charge of each contract are familiar with its terms and conditions. Health needs to ensure proper procurement planning before the expiration of the contract to minimize possible procurement guideline violations.

Health has recognized the need for additional procurement training and has developed and provided additional training. However, management needs to ensure all employees assigned this responsibility receive appropriate training. In addition, Health has not developed procedures for determining contract responsibility and contract oversight. This is important so that employees have a clear understanding of their responsibilities to ensure adequate and proper contract management.

Management should complete the assignment of the responsibility to manage contracts and communicate those responsibilities including the required contract elements and the assignment of contract administrators while maintaining central oversight. Health should continue to provide training to appropriate personnel conveying the process and its importance and require each work unit to maintain a list of all their contracts. Management should also update Health's policies and procedures to include unique agency contract management procedures.

Properly Write-Off Bad Debt and Comply with Accounts Receivable Procedures

While Health has made some progress in collecting overdue accounts, several local health departments are not writing off sufficient past due uncollectable receivables. Nine health districts did not write off uncollectable accounts on a quarterly basis as stated in Health's policies and procedures manual. Of $4,155,477 in total gross receivables at June 30, 2001, $2,942,607 (71 percent) is past due. Health has a performance standard for past due balances as a proportion of total receivables, which is 20 percent.

Most of these past due uncollectable accounts are greater than a year past due and districts are not taking proper steps to clear the debt out of the accounting records. Leaving old and uncollectable accounts on the accounting records distracts resources that local health departments could use to collect current accounts rather than maintaining these old accounts.

Local health departments should review and evaluate accounts for write-off quarterly, as stated in Health's policies and procedures manual. Management should monitor the local health department's compliance in following the write-off procedures. In addition, management should measure and compare actual performance levels against the standard on a quarterly basis to determine whether Health should develop other procedures to assist in enhancing collections to meet the performance standard goal.

Improve Method of Allocating Local Health Department Funding

Health uses a methodology for allocating state funds to the local health departments that is over ten years old and does not reflect changes in the makeup of the localities, services, and population. In addition, according to the Joint Legislative Audit Review Commission (JLARC), the disparity in local funding for public health services actually increased and has imposed a special burden on local health departments in localities that have experienced the greatest growth in population.

Health developed the following two strategic plan objectives based on recommendations issued in JLARC's January 2000 report:

- Update and validate reports depicting each locality's match formula amount by fiscal year based on Senate Document 11 recommendations provided by JLARC and associated allocation processes.

- Develop plans and procedures to implement changes in the allocation methodology to promote greater equity in local contributions and to allocate state funds according to mandated services and community needs.

In order to change the allocation methodology, Health should establish staffing standards and identify local public health service needs. While Health has collected data and begun reviewing environmental health staffing standards, it has not completed this project due to funding shortages.

Health needs to request and obtain the necessary resources to complete its strategic plan objectives to update the allocation methodologies for local health departments. Senior Health management should periodically review the progress made to accomplish this important goal. Completion of this JLARC recommendation and Health's strategic plan objective would ensure greater equity in local contributions and allocations of state funds in support of community needs.

VIRGINIA DEPARTMENT OF HEALTH
Richmond, Virginia

Robert B. Stroube, MD, MPH, Acting Health Commissioner

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