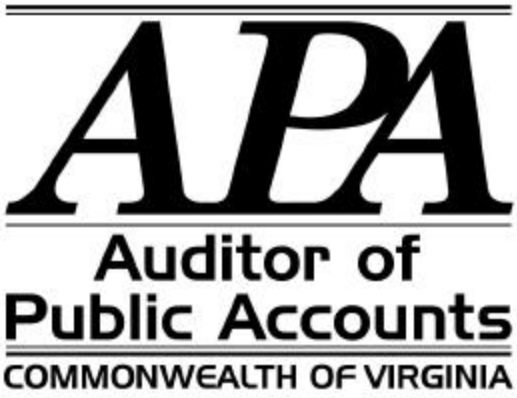
DEPARTMENT OF HEALTH

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2000



AUDIT SUMMARY

Our audit of the Virginia Department of Health for the year ended June 30, 2000, 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 Project Plan Using a Realistic and Reliable Funding Scheme
- Complete an IT Strategic Plan and a Comprehensive Annual Work Plan for the Office of Information Management
- Permanently Fill Critical Office of Information Management Positions
- Complete Information Security Program
- Strengthen WIC Information Security
- Strengthen Controls Over Redeemed WIC Checks to Detect and Prevent Fraud
- Strengthen Controls Over Unissued WIC Checks
- Conduct On-Site Visits to Ensure Compliance With WIC Federal Regulations
- Comply With Procedures and Strengthen Controls Over Small Purchase Charge Cards
- Manage Contracts and Update Procurement Policies and Procedures
- Strengthen Controls Over Cooperative Agreements
- Perform Immunization Site Visit Monitoring in Compliance With Federal Award
- Ensure Complete Immunization Documentation on Patient Records

- T A B L E O F C O N T E N T S -

Commonwealth of Virginia

Walter J. Kucharski, Auditor

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

January 20, 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, 2000. 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 the Department's internal control, and test compliance with applicable laws and regulations. We also reviewed Health's corrective actions of audit findings from the prior year.

Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observations of the Department'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

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 control and its operation that we considered 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," "Nutritional Program for Women, Infants and Children (WIC)," and "Other Internal 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 instances of noncompliance that are required to be reported under Government Auditing Standards, which are discussed in the findings entitled, "Strengthen Controls Over Redeemed WIC Checks to Detect and Prevent Fraud," "Strengthen Controls Over Unissued WIC Checks," " Conduct On-Site Visits to Ensure Compliance With WIC Federal Regulations" "Perform Immunization Site Visit Monitoring in Compliance With Federal Regulations," "Ensure Complete Immunization Documentation on Patient Records."

Health has not completed adequate corrective action with respect to the previously reported findings entitled, "Complete IT Strategic Plan," "Complete Information Security Program," "Strengthen WIC Information Security," "Fill Critical Office Of Information Management Positions," and "Strengthen Controls Over Cooperative Agreements." Accordingly, we included these findings in the sections entitled, "Office of Information Management," "Nutritional Program for Women, Infants and Children (WIC)," and "Other Internal Control Findings and Recommendations."

This report is intended for the information 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 March 13, 2001.

AUDITOR OF PUBLIC ACCOUNTS

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AGENCY OVERVIEW

The 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.

Health operates through its central office, which includes 35 health districts that operate 119 local health departments. During fiscal year 2000, local health departments provided services to approximately 760,000 different patients who accumulated over 1.2 million patient visits. In addition to the patient visits, the local health departments administered over 670,000 immunizations.

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, prevention, health education, and maintenance of sanitation and drinking water infrastructure. Additionally, most of the local health departments provide a variety of non-mandated indigent health care services for persons who cannot otherwise afford them.

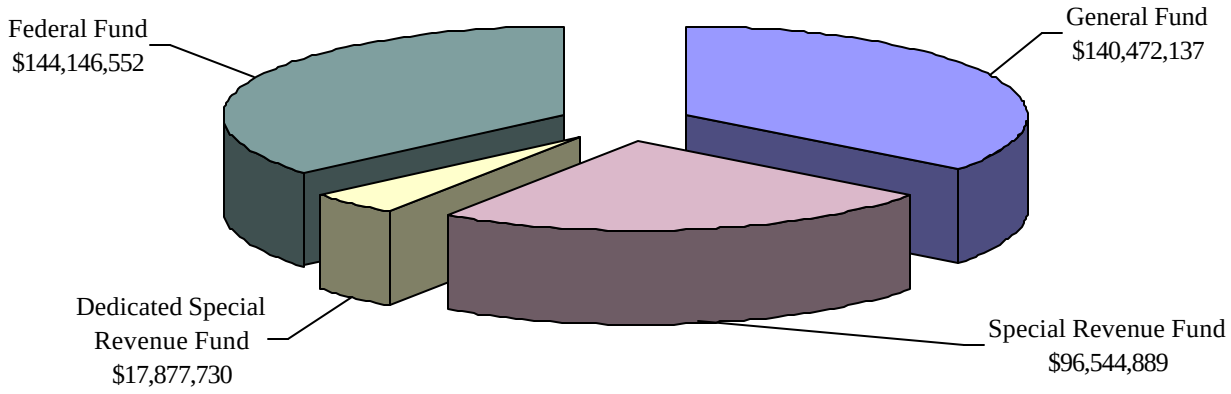
The State Board of Health, appointed by the Governor, defines its mission as, "To provide leadership in planning and policy development for the Commissioner and the Virginia Department of Health to implement a coordinated, prevention-oriented program that promotes and protects the health of all Virginians. 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, defines income limitations for recipients for specific services, and sets fees for the local health departments.

FINANCIAL OPERATIONS

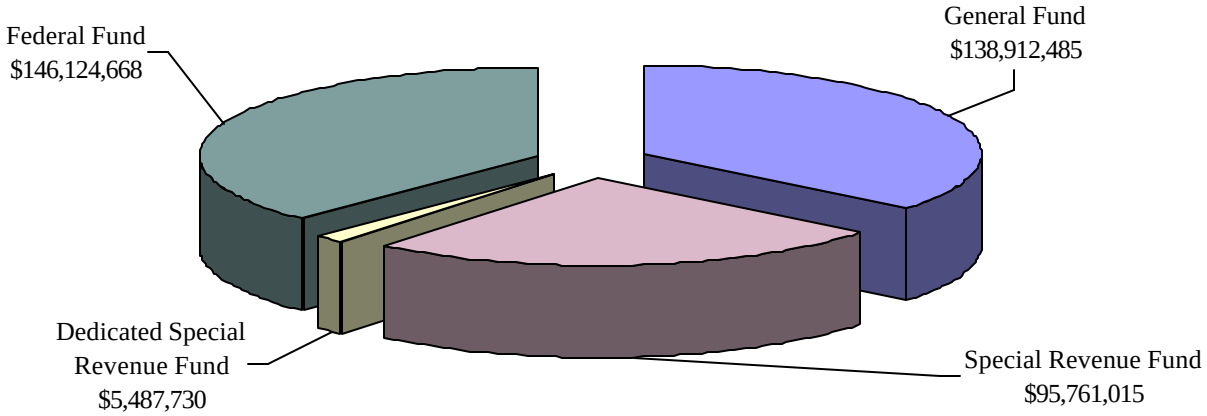
As illustrated below, Health received over $399 million in funding during fiscal year 2000. In addition to the $144.1 million in federal revenue, Health brought forward unspent funds of $2.8 million. The single largest source of federal revenue is the Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, which accounts for more than 50 percent of federal revenue and expenses. The section 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 which enhances 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 includes 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 state employees.

Funding Sources - Fiscal Year 2000



Expenditures - Fiscal Year 2000



OFFICE OF INFORMATION MANAGEMENT

The Office of Information Management (OIM) has had a history of problems with the implementation and management of its information systems development projects. Currently, as well as historically, factors such as the high turnover of leadership positions and inadequate funding have placed OIM information systems projects at risk. Presently, OIM's largest and most complex issues involve the continual changes to and successful implementation of the Virginia Information Systems – Integrated On-line Network (VISION).

The direction of VISION has changed several times in the last year. As described in our previous reports, the original VISION project went into operation with numerous deficiencies. To address the most serious issue, management concluded that the information brought into VISION needed correcting. Late in 1999, management decided that in addition to the data cleanup, the recently implemented system did not meet Health's needs. Therefore, management decided to rewrite the system into an internet-based application, which will result in the new Web-VISION. 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. In August 2000, the project team encountered an unanticipated problem with the Oracle Accounts Receivable module that resulted in the need for additional customizing of the module. This delayed the projected implementation date to December 2001. Because of the accounts receivable issue and lack of funding and other resources, management has, as of January 2001, once again revised the project plan. The current implementation date is April 2002. In the past year, management has delayed the project's implementation date by 15 months.

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

Develop a Project Plan Using a Realistic and Reliable Funding Scheme

Management does not have a realistic and reliable funding scheme for Web-VISION. Plans included requesting and receiving additional appropriation, which neither the Governor, nor the General Assembly included in the current budget process, and shifting resources from other non-service areas to this project.

Management can internally shift resources from non-service areas and as it appears that this funding is the only method available, management should adopt a more realistic timeframe and schedule for implementing Web-VISION. Also, management needs to evaluate what functions it can afford. Within the last year, the plan for the Web-VISION project has undergone significant changes. While increasing functionality, the changes have also increased the budget by $2.5 million, as well as delayed the projected implementation date by over a year.

Realistic and reliable project, budget, and funding plans are necessary for all large implementation projects. These documents provide the necessary guidance to establish timeframes and resource needs. Without these documents, the project team does not have the necessary direction for successful implementation. Management needs to set these plans within the available funding sources and develop its plan accordingly. As part of this process, management also needs to control changes to functionality to those that the system development project can deliver within the available resources.

Complete an IT Strategic Plan and a Comprehensive Annual Work Plan for the Office of Information Management

Health has not completed an information technology strategic plan or a comprehensive annual OIM work plan. An information technology strategic plan helps management identify current information technology activities and how these activities relate to the future goals of the agency. The plan allows management to examine how changing needs and demands may affect the planned results. The plan should support the preparation of an agency-wide information technology budget and prioritize large and small projects within the available funding.

Part of strategic planning is setting goals and projects that the information technology staff can complete during the year. These goals and projects must include those information technology projects managed by other sections other than OIM. These expectations form the basis of a comprehensive information technology work plan. Without this annual work plan, it is difficult for OIM or other sections to prioritize and plan their work in alignment with management's information technology objectives and the strategic plan.

In November 2000, management began the initial stages to create an information technology strategic plan. However, management must continue towards the completion of an information technology strategic plan and a comprehensive annual OIM work plan. Once completed, management should also ensure that it

annually commits the necessary resources and responsibilities to update the information technology work plan and information technology strategic plan.

Permanently Fill Critical Office of Information Management Positions

Health has temporarily assigned staff to fill several key information technology management positions. These temporary assigned staff fill the critical positions of Chief Information Officer (CIO), Agency Security Officer, OIM Site Security Officer, Configuration Manager, and OIM Database Manager.

The Commissioner deferred the permanent replacement of the Acting CIO to reduce further delays in the implementation of Web-VISION. The Commissioner determined that the Web-VISION project is currently at a critical position and the replacement of the CIO could substantially hinder the project's progression. Health plans on recruiting for the permanent CIO by June 2001 and plans on allowing sufficient time for the new CIO to fully adjust with the help of the Acting CIO in order to prevent any further Web-VISION delays. While this is a reasonable plan, we continue to strongly urge Health to permanently hire an experienced CIO as soon as possible to continue the progression of other project development and the operation of information processing systems.

The Acting CIO, the Acting Agency Security Manager, and the OIM Site Security Officer must also work to fulfill their other full time position duties elsewhere within Health. These highly experienced and dedicated employees will find it difficult to devote sufficient time to complete the work of two positions.

In addition, there is a conflict between the duties of the Acting Security Officer and that employee's other full time position of Systems Network Manager. Proper separation of duties would preclude the Security Officer position from having direct access to the computers and networks. It is imperative in assigning employees acting positions that their permanent position does not conflict sufficiently to compromise Health's information technology's system of internal control.

Health needs to permanently fill essential information technology management positions as soon as practical. In the interim, senior managers must ensure that all information technology activities meet Health's overall goals and objectives and maintain an adequate system of internal control.

Complete Information Security Program

Health has not completed an information security program appropriate for its information technology environment. The Department of Information Technology Planning requires that all agencies plan such a program. The plan must address the following issues:

- A business impact analysis that defines the agency's sensitive information systems
- A risk analysis process and assessment that identifies the risks to the sensitive information systems and countermeasures required to reduce risks to an acceptable level
- A contingency management plan that provides for the continuation of critical business functions in the event of disruptions or disasters
- Implementation of security safeguards based on the risk assessment
- Security awarene ss and training programs

In response to our previous recommendations, management has made an effort towards completing a contingency management plan by requiring each division and department within Health to complete a business resumption plan. However, Health does not have a work plan to test the business resumption plans. Without testing a sample of the plans, there is no way to ensure its adequacy. In addition, Health does not

have an overall agency business resumption plan, a current business impact analysis, or a risk analysis and assessment.

Health should complete an information security program based on the standards listed above. Management should ensure that the program is adequate for their technology environment to ensure the integrity of all systems and information. The information security program should also ensure compliance with all federal information security requirements described in the Health Insurance Portability and Accessibility Act (HIPAA).

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 seeks to provide assistance for good health during critical times of growth and development in order to prevent health problems through food supplements and education. Each month during fiscal 2000, an average of 128,613 citizens participated in the WIC program. Health administers the WIC program through local health departments who determine qualifying criteria. Health anticipates implementing a new information technology application (WIC-Net) for the WIC program, but this system has incurred ongoing delays.

Strengthen WIC Information Security

WIC-Net is currently behind schedule for implementation. The delays in implementing the new WIC system have continued to prevent Health from improving security over WIC transactions. Health employees can set up recipient accounts, enter and update recipient eligibility information, and approve recipients for benefits without supervisory review or independent verification. These employees also reconcile unmatched WIC checks. This lack of separation of duties increases the risk that employees can initiate incorrect or fraudulent transactions. The WIC-Net system should correct these weaknesses.

Health originally planned to implement WIC-Net in January 1995 and now plans to pilot the WIC-Net system in the fall of 2001. The following problems have contributed to the delay:

- Lack of documentation of technical testing and untested program components
- Lack of structured user acceptance testing with no documentation of successful testing and limited documentation of problems
- Lack of technical project management with resulting fragmentation
- Loss of functionality in the Financial Management Module resulting from DIT changes to the system
- Limited testing of changes and poor documentation of the testing results

Management should properly address identified security issues and ensure proper separation of duties and adequate security within the system before implementing the WIC-Net system. Health should maintain the management and technical expertise acquired in order to meet the new implementation date of October 2001. In an effort to meet this date, Health has developed an executive committee to monitor the progress of the project's completion.

Strengthen Controls Over Redeemed WIC Checks to Detect and Prevent Fraud

Health does not review WIC checks to determine if vendors redeem the checks for more money than the value of food provided the participant. One reason Health does not adequately monitor WIC check redemption is that its WIC policies and procedures manual and its WIC vendor manual conflict with each other. Each manual specifies different redemption limits. Inadequate controls could allow WIC fraud to go undetected and unpunished.

We identified several WIC checks for food packages where the vendor charged an excessive amount considering the food listed on the WIC check. In addition, numerous WIC checks had food packages that exceeded Health's $75 limit for manual WIC checks. Many of the WIC checks over $75 also had excessive amounts considering the food listed on the WIC check. Inadequate review of redeemed WIC checks allows vendors and participants to fraudulently profit from the program reducing the funds available for other participants.

Health should develop and implement procedures to review redeemed WIC checks for reasonableness to find fraudulent vendors and participants. In addition, Health should revise its policies and procedures, as well as its vendor manual to ensure that consistent policies and procedures are in place to communicate to all parties that Health will detect, investigate, and punish all fraudulent transactions.

Strengthen Controls Over Unissued WIC Checks

There is a lack of separation of duties for unissued WIC Checks in that the same individual orders, receives, issues, assigns or authorizes, and tracks the inventory of WIC manual checks. This employee orders the checks from the bank; verifies and records receipt of the checks, has general custody of the checks, and also enters the checks into the IRMA system. In addition, no other employee reconciles the receiving and shipping records to the inventory on hand in the Central Office.

Failure to properly separate duties and reconcile inventory records could result in the misuse and mishandling of manual WIC checks. The Code of Federal Regulations (CFR) Section 246.12 states that the state agency shall control and provide accountability for the receipt and issuance of supplemental foods and food instruments.

Management should re-assign some of the WIC instrument responsibilities to ensure there is a proper separation of duties. In addition, a supervisor should reconcile the receiving and shipping records to the inventory on hand to ensure accountability of all food instruments.

Conduct On-Site Visits to Ensure Compliance With WIC Federal Regulations

The Financial/Administrative team did not conduct management evaluations of on-site visits for each local health district as required by federal regulations for the WIC program. Also, there is no two-year monitoring schedule that determines the evaluation of each district. In addition, only one employee is performing all of the tasks necessary to complete the evaluations including scheduling the on-site visits, determining and performing audit procedures, and writing the reports without supervision.

Federal regulations state that the agency must conduct local management reviews that include on-site visits of at least 20 percent of the clinics in each local health district during a two-year cycle. Without a monitoring schedule indicating the districts to evaluate, Health could miss evaluating a district, which would result in non-compliance with the federal regulations. Adequate internal controls include supervisory reviews to ensure that staff adequately review and report all issues. Lack of compliance with the federal regulations could result in Health losing federal funding.

Management should obtain the necessary resources and develop a plan to complete the required number of on-site visits. This plan should include a two-year monitoring schedule that indicates the on-site evaluation of each local health district to ensure the inclusion of all districts. In addition, management should implement a review process to ensure compliance and adequacy of on-site evaluations.

In response to our recommendations, management has developed a plan and schedule for on-site visits in an effort to meet compliance requirements beginning with fiscal 2001. In addition, management has formed a "Program Integrity Unit' to provide oversight and ensure adequacy of site reviews.

OTHER INTERNAL CONTROL FINDINGS AND RECOMMENDATIONS

Comply With Procedures and Strengthen Controls Over Small Purchase Charge Cards

Eighty-eight percent of the sample of cardholders we selected did not maintain purchase logs that complied with Health and CAPP Manual procedures. Ninety-four percent of cardholders in the sample did not reconcile their monthly cardholder statements. In addition, supervisors did not review or approve the purchases or sign and certify the monthly statements. Our testing also disclosed missing receipts and a missing cardholder monthly statement.

Health's Department Administrative Management Manual (DAMM) and Commonwealth Accounting Policy and Procedures Manual (CAPP) require each small purchase cardholder to establish a purchasing log and to reconcile the purchasing log each month. These procedures also require the purchasing log, the reconciliation, and the charge card statement be reviewed and approved each month by the cardholder's supervisor. Supervisory reviews are necessary to ensure the propriety of purchases identified on the purchase logs. The reconciliations also ensure that charge card vendor is correctly charging the agency. Without the log and its reconciliation and the statement review and approval, unauthorized purchases will go undetected. In addition, Health cannot assure that its charge card bill is correct. This lack of internal control could lead to fraudulent charges and incorrect payments.

Employees are also sharing charge cards and staff primarily use the cards issued to most supervisors or directors. Health's policy manual specifically states, "It is critical that cards be used only by the employee it is issued to." Health needs to issue cards to appropriate employees authorized to make purchases.

Health also has an excessive number (58) of program administrators for the number of cardholders (200). Program administrators have the authority to request cards, terminate cards, and change cardholder purchasing limits. Health needs to significantly reduce the number of program administrators to ensure adequate controls and strengthen program management.

Management should develop and implement a training program to adequately train cardmembers and supervisors on all policies and procedures including maintaining a purchasing log, the necessity of supervisory reviews, and the importance of the reconciliation and certification process. Management should issue cards to employees authorized to make purchases and discontinue the practice of card sharing. Strengthening the internal controls over the Small Purchase Charge Card Program will reduce the risk of fraudulent charges and ensure purchases are proper.

In response to our recommendations, management has developed and distributed a purchasing log in an effort to standardize and enforce compliance with policies and procedures. Management has also agreed to re-evaluate the number of program administrators.

Manage Contracts and Update Procurement Policies and Procedures

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. We found several contract extensions that were not executed until several months after the contract expiration dates and no contract designated a contract administrator. Management is unsure of how many or what contracts currently exist. In addition, internal policies and procedures are outdated. Health spent $78 million during fiscal year 2000 for contractual services representing 20 percent of total expenditures.

Contract files should name a designated contract administrator and assign their responsibilities to ensure compliance with contract requirements. This will help ensure Health receives the contracted services or goods. It is imperative that management knows who is in charge of each contract. Only contract officers with the appropriate procurement authority, and the approval of management, should authorize changes to an existing contract. Allowing individuals unfamiliar with procurement guidelines to authorize changes to a contract leads to violations of state procurement policies and is inefficient. Health needs to ensure proper procurement planning before the expiration of the contract to minimize possible procurement guideline violations.

Management should assign responsibility for the development and maintenance of a process to track contracts and communicate required contract elements while maintaining central oversight. Health should also continue to provide additional training conveying the process and its importance and require each work unit maintain a list of all their contracts. Management should also update policies and procedures to include current procurement guidelines and purchasing authority for Health personnel.

Strengthen Controls Over Cooperative Agreements

Our audit found that 12 percent of the cooperative agreements sampled for fiscal 2000 were signed at year-end. Furthermore, year-end settlements and reconciliations are not completed and submitted timely to central office.

Cooperative agreements cover the fiscal year from July 1 through June 30 of each year. Health does not get most signed contracts before January and many remain unsigned until year-end. Using this process, the local health departments operate most of the year without a formal agreement in place.

For the year ended June 30, 2000, the health districts received budgeting figures in November 1999, and had until February 2000, to return signed cooperative agreements to the central office. This is eight months after the start of fiscal year. However, only 37 percent of sampled localities complied with this deadline. The cooperative agreements establish the maximum amount of funding Health will contribute to the operation of the local health department, the financial contribution the locality will make, and the services that the local health department will provide. Without signed cooperative agreements, the localities base their quarterly payments on the amount established for the previous year, which may not be an accurate figure. The locality must then adjust the payments during the second half of the fiscal year to match the cooperative agreement, which was signed late.

Localities submit year-end reconciliations to the fiscal office up to three months after the close of the fiscal year. Central office then takes an additional 60 to 90 days to resolve questions and discrepancies related to the year-end reconciliation. Therefore, implementations of the resolutions do not occur until the middle of the following fiscal year. This also causes a delay in the signing of the cooperative agreements.

Health needs to review and re-engineer its process so that it can finalize the agreements before the start of the fiscal year. In addition, management should work to improve compliance with appropriate

deadlines and improve the timely completion of year-end settlements between the districts and localities. Timely settlements will permit making adjustments and applying them to the proper fiscal year.

Perform Immunization Site Visit Monitoring in Compliance With Federal Award

Health did not complete the required percentage of site visits for subrecipient monitoring and is not complying with the Federal Immunization Grant award to conduct annual site visits for 25 percent of all provider sites as agreed upon between Health and the federal agency. Health completed only 14 percent of the private provider site visits for fiscal 2000. In addition, Health did not conduct any site visits for public providers (local health departments). Also, there is no annual plan that identifies providers selected for site visits.

An insufficient number of site visits and monitoring plan could result in noncompliance of federal guidelines and may result in immunizations administered to ineligible participants. Site visits determine if providers understand program regulations, give immunizations only to eligible participants, and properly store and maintain the vaccines to minimize costs.

Currently, Health conducts a limited number of site visits of private providers each quarter by considering risks such as known problems or excessive inventory ordering. This approach does not consider all private providers for inclusion for site visits due to insufficient resources. Health has requested an additional three employees to assist with the performance and completion of required site visits in accordance with federal compliance guidelines.

Management should develop a plan that considers the inclusion of all providers to ensure compliance with program and federal requirements. Management should continue to obtain the necessary resources to complete the planned required site visits.

In response to our recommendation, we understand that management has developed an annual plan that includes site visits for both private and public health providers to ensure compliance with regulations.

Ensure Complete Immunization Documentation on Patient Records

Health did not adequately document patient information for the Federal Vaccines for Children (VFC) Immunization Grant as required by federal guidelines. Three of ten patients tested in the Richmond and Fairfax Districts did not document the criteria for eligibility on the consent form or in the Health Management Information System (HMIS). In addition, the name and title of the person administering the vaccine was not included on either the consent form or in HMIS for three of five sampled patients in the Fairfax District.

Vaccine accountability includes ensuring that VFC vaccines go only to VFC-eligible children. Therefore, patient information documented in the patient's record should include both patient eligibility and the name and title of person(s) administering the vaccines. This is also important to ensure children have complete immunization records.

Federal regulations state that the patient must meet certain eligibility criteria. In order for a provider to determine that a patient meets the federal criteria, they must ascertain and document which criteria the patient has met to receive immunization. Documentation should identify whether the patient qualified for immunization by meeting at least one of the following criteria: Medicaid, uninsured, underinsured, Native American, or American Alaskan. This is important to ensure that all children who receive vaccinations are eligible.

Lack of compliance with federal regulations could result in incomplete immunization records or vaccine administration to ineligible patients. Further, federal regulations require that a child's immunization

record include the name of the person administering the vaccine, so that Health can show that the provider was a licensed professional. In addition, the provider must document the administration of the vaccine.

Management should provide training and communicate the expectations and requirements of the program with the appropriate district program personnel. Management should also ensure compliance of these requirements during scheduled district site visits.

In response to our recommendation, Health began a training program for all immunization coordinators whose responsibility is to perform annual district quality assurance reviews.

VIRGINIA DEPARTMENT OF HEALTH
Richmond, Virginia

E. Anne Peterson, M.D., M.P.H.
Commissioner

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