Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Iron Mountain, Michigan

Report No. 03-01387-126 **July 14, 2003**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Contents

	Page
Executive Summary	i
Introduction	1
Medical Center Profile	1
Objectives and Scope of CAP Review	1
Results of Review	3
Organizational Strengths	3
Opportunities for Improvement	3
Controlled Substances Accountability	3
Automated Information Systems	4
Patient Waiting Times	5
Government Purchase Card Program	6
Quality Management	7
Appendices	
A. VISN 12 Director Comments	8
B. Medical Center Director Comments	9
C. Report Distribution	16

Executive Summary

Introduction

During the week of May 19-23, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Iron Mountain, Michigan. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 4 fraud and integrity awareness briefings to 94 employees.

Results of Review

The medical center was clean and neat; the Hoptel Program, clinical laboratory security, emergency preparedness, and environment of care functions were operating satisfactorily; and billing activities for contract services were properly monitored. We recommended that the Veterans Integrated Service Network (VISN) Director require the Medical Center Director to improve:

- Management controls over controlled substances.
- Automated information systems (AIS) security.
- Processing time for enrollment applications and appointment waiting times.

We also suggested that the VISN Director require the Medical Center Director to strengthen management controls over the Government Purchase Card Program, and improve QM data analysis and documentation of corrective actions.

VISN Director Comments

The VISN and Medical Center Directors agreed with the findings, recommendations, and suggestions and provided acceptable implementation plans. (See pages 8-15 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is an acute care facility that provides a broad range of inpatient and outpatient services. Outpatient care is also provided at six community-based outpatient clinics (CBOCs) located in Hancock, Menominee, Marquette, Ironwood, and Sault Saint Marie, Michigan and Rhinelander, Wisconsin. The medical center is part of VISN 12, and serves a veteran population of about 58,000 in the Upper Peninsula of Michigan and 11 counties of Northeastern Wisconsin.

Programs. The medical center provides medical, surgical, psychiatry, and specialty services. The medical center has 17 acute care operating beds (12 medical/surgical and 5 intensive care), and a 40-bed Nursing Home Care Unit (NHCU). The medical center has several referral and treatment programs, including the Psychosocial Residential Rehabilitation Treatment Program, Tele-Medicine, and outpatient mental health. The medical center also has contractual agreements for hemodialysis, total parenteral nutrition, and a reciprocal agreement with the Dickinson Health Care System to provide laboratory and radiology services.

Affiliations and Research. The medical center has no medical school affiliations, but has contractual arrangements with local educational institutions for licensed practical nurse, advance practice nurse, audiology and speech therapy, and pharmacy students through Northern Michigan University, Bay De Noc Community College, and Ferris State University, respectively. The medical center does not conduct or participate in research projects.

Resources. In fiscal year (FY) 2002, medical care expenditures totaled over $47 million and the FY 2003 medical care budget is over $50 million. FY 2002 staffing totaled 357 full-time equivalent employees, including 15 physicians and 103 nursing employees.

Workload. In FY 2002, the medical center treated 15,508 unique patients. The medical center provided 4,816 inpatient days of care in the hospital and 12,801 in the NHCU. The inpatient care workload included 1,077 discharges, and the average daily census was 13 for the hospital and 35 for the NHCU. The outpatient care workload in FY 2002 was 109,330 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

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

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

Automated Information Systems Security	Government Purchase Card Program
Clinical Laboratory Security	Hoptel Program
Contract Administration	Patient Waiting Times
Controlled Substances Accountability	Quality Management
Emergency Preparedness	Tele-Medicine Programs
Environment of Care	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The survey indicated high levels of patient and employee satisfaction and did not disclose any significant issues. The survey results were provided to medical center management.

During the review, we presented 4 fraud and integrity awareness briefings to 94 medical center employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The CAP review covered medical center operations from October 1, 2001, through May 22, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strengths

The medical center was clean and neat, which demonstrated a commitment by top management to maintaining an appropriate environment for patient care.

Tele-Medicine Programs

Tele-Home Care Pilot Program. The Tele-Home Care Pilot Program was initiated at the medical center in December 2002 for veterans who had difficulty accessing VA medical care because of physical limitations or geographical distance. Two pilot program patients were issued monitoring units that connected to their home telephone lines. The monitoring units included a video camera, stethoscope, pulse oximetry, blood pressure cuff, thermometer, and scale. A Tele-Home Care nurse educated the patients on use of the units prior to installation. During Tele-Home Care sessions, the Tele-Home Care nurse uses a base computer and camera to monitor breath and heart sounds, track blood pressure, and read patients' temperatures. The Tele-Home Care Program has decreased the number of hospital admissions and walk-in visits for the pilot program patients. When the program is fully implemented, the medical center expects to serve up to 10 patients with each base computer.

Tele-Pathology Program. The Tele-Pathology Program has resulted in improved access for veterans to medical expertise that was not available in the Upper Peninsula of Michigan. The medical center does not have a staff pathologist to analyze specimens and, therefore, uses pathologists at the Clement J. Zablocki VAMC in Milwaukee, Wisconsin. At VAMC Iron Mountain, a video camera is mounted on a motorized and robotic controlled microscope. Pathologists at the Clement J. Zablocki VAMC use computers to control microscope stage movements, focus, and magnification at VAMC Iron Mountain. The system has special video cameras, microphones, and annotation devices that allow teleconferencing by pathologists at the Clement J. Zablocki VAMC with a pathology technician at VAMC Iron Mountain. The Tele-Pathology program has reduced the turn around time for pathology results at VAMC Iron Mountain by more than 50 percent.

Opportunities for Improvement

Controlled Substances Accountability – Management Controls Needed Improvement

Conditions Needing Improvement. Unusable controlled substances were not destroyed quarterly, as required by VA policy, and the controlled substances inspection program needed improvement. The following conditions required management attention:

- During the period October 1, 2000, through April 30, 2003, unusable controlled substances were destroyed only six times, instead of quarterly (10 times), as required by VA policy.

- The medical center draft policy allowed inspectors to conduct eight inspections within a 12-month period. VA policy provides that no inspector may conduct more than six inspections within a 12-month period.

- Eleven of 60 monthly inspections (18 percent) were not performed in 5 areas during the period April 2002 through March 2003. Additionally, the inspections that were conducted were generally conducted on predictable days. VA policy requires unannounced inspections of controlled substance on a monthly basis.

- During our observation of the inspection process for the pharmacy vault and patient ward, a pharmacist and a nurse performed the physical counts instead of the inspectors, as required by VA policy. Additionally, a pharmacist entered the working stock vault and filled a prescription during the inspection and did not notify the inspectors. To ensure an accurate count, the pharmacist should have notified the inspectors that a prescription was being filled. Instead, the inspection process was interrupted, while a new inventory sheet was printed to account for the recently filled prescription.

- A discrepancy in the quantity of a controlled substance was identified and resolved during the ward inspection, but was not reported to the Medical Center Director. VA policy requires that inventory discrepancies be reported to the Medical Center Director.

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

a. Unusable controlled substances are destroyed quarterly.
b. Medical center policies are revised to limit inspectors to six inspections within a 12-month period.
c. Unannounced inspections of controlled substances are conducted monthly.
d. Controlled substances inspectors conduct the physical counts of controlled substances during inspections.
e. The inspection team is notified when prescriptions are filled during inspections.
f. Discrepancies identified during monthly inspections are reported to the Director.

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

Automated Information Systems – Security Needed Improvement

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

- The ISO was not trained in the audit features of the Veterans Health Information Systems and Technology Architecture (VISTA) application.

- Contract staff providing home-based medical transcription services to the medical center had not received annual AIS refresher training.

- The medical center did not require or develop a contingency plan for a contract CBOC.

- Background investigations were not conducted for 25 of 31 employees working in sensitive positions. The medical center had requested the investigations, but did not follow up with the Office of Personnel Security to determine the reasons the investigations were not conducted.

- Prior to March 2003, the ISO did not monitor employee access to the medical records of other employees, as required by VA policy.

- The security level (permissions) for a shared drive was set to "everyone," which allowed access to patients' names and social security numbers by anyone with access to the shared drive. VA policy requires that sensitive information be protected and made available only to those having a need for the information.

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

a. The ISO is trained in the audit features of VISTA.
b. AIS refresher training is provided to contract staff annually.
c. A contingency plan is developed for the contract CBOC.
d. Periodic follow-up is conducted with the Office of Personnel Security concerning the status of background investigations requested for employees working in sensitive positions.
e. The ISO continues to monitor employee access to the medical records of other employees.
f. Shared drive security levels are reset to restrict access to sensitive information to those having a need for the information.

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

Patient Waiting Times – Processing Time For Enrollment Applications and Appointment Waiting Times Needed Improvement

Condition Needing Improvement. Enrollment applications and appointments for new enrollees to primary care were not processed timely. A sample of 17 of the 580 veterans' Applications for Health Benefits (VA Form 10-10EZ) received by the medical center during the past 6 months showed the following conditions needed management attention:

- The medical center averaged 35 days to enroll new patients. VA policy requires that enrollment applications be processed within 7 days of receipt.

- The medical center averaged 238 days to see new patients scheduled for primary care appointments. VA policy requires that patients be seen within 180 days of the date the appointment is requested.

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

a. Enrollment applications are processed within 7 days of receipt.
b. Appointments for new enrollees in primary care are scheduled within 180 days of the dates the appointments are requested.

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

Government Purchase Card Program – Controls Should Be Strengthened

Conditions Needing Improvement. During the 16-month period ending March 17, 2003, cardholders completed 9,053 transactions valued at about $3.7 million. The following areas needed management attention:

- As of April 2, 2003, cardholders had not completed the reconciliation process for 451 transactions valued at about $161,000, including 174 transactions valued at $60,678 that were over 180 days old. VA policy requires that purchase card transactions be reconciled before they are 30 days old.

- Approving officials did not certify 759 transactions valued at $354,813 within 14 days after reconciliation, as required by VA policy. The uncertified transactions ranged from 15 to 382 days old, including 116 transactions valued at $58,576 that were older than 60 days.

Suggested Improvement Action. We suggested that the VISN Director require the Medical Center Director to ensure that:

a. Cardholders complete the reconciliation process for purchase card transactions before they are 30 days old.
b. Approving officials certify purchase card transactions within 14 days after reconciliation.

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

Quality Management – Data Analysis and Documentation of Corrective Actions Needed Improvement

Conditions Needing Improvement. QM managers and program coordinators did not fully analyze QM data, or consistently document QM corrective action plans and their effectiveness. The following conditions needed management attention:

- QM managers and program coordinators collected data in several areas, but did not consistently complete detailed analyses, or trend the applicable variables. For example, although patient complaints were graphed by type of complaint, the data were not analyzed for provider, service, location, or other trends. VHA policies and standards by the Joint Commission on Accreditation of Healthcare Organizations require critical analysis of patient complaints.

- QM managers and program coordinators did not consistently include measurable goals in corrective action plans, or evaluate the effectiveness of corrective actions taken. For example, the Medical Staff Meeting minutes documented that two physicians failed to comply with medical center policies for medical records documentation and narcotics prescriptions; however, action plans to correct the deficiencies were not documented. The Chief of Staff (COS) told us that he verbally counseled the two physicians and conducted follow-up to ensure that the deficient practices had stopped. However, there was no documentation of intervention by the COS, or the methods used to measure the effectiveness of corrective actions taken.

Suggested Improvement Action. We suggested that the VISN Director require that the Medical Center Director implement procedures to:

a. Thoroughly analyze and trend pertinent QM data.
b. Document corrective action plans and their effectiveness in meeting measurable goals.

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

Appendix A

VISN 12 Director Comments

Department of Veterans Affairs

MEMORANDUM

Date: July 1, 2003

From: Network Director, VISN 12 (10N12)

Subj: Response To Draft Report - OIG CAP Review of Iron Mt. VAMC (Project No. 2003-01387-R3-0087)

To: Assistant Inspector General For Auditing (52)

1. In response to the Draft Report of the Combined Assessment Program Review of the Iron Mt. VA Medical Center, attached please find comments provided for the Director of Iron Mt.

2. I have reviewed and concur with the attached response.

/s/
Joan E. Cummings, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: July 1, 2003

From: Medical Center Director, VA Medical Center, Iron Mountain, MI (585/00)

Subj.: DRAFT REPORT RESPONSE: Combined Assessment Program Review - VA Medical Center, Iron Mountain, MI (Project No. 2003-01387-R3-0087)

To: Assistant Inspector General for Auditing (52)
THRU: Network Director VISN 12 (10N12) /s/

1. Attached are our comments to the Combined Assessment Program Review of the Iron Mountain, MI, VA Medical Center draft report. The comments indicate concurrence or non-concurrence, and detail corrective action plans and completion dates for each Recommendation and Suggestion.

2. We appreciate the professionalism and assistance of the OIG in performing this review. If we can provide any additional information, or if you would like to discuss this response, please feel free to contact me at (906) 774-3300, extension 32000.

/es/
Deborah A. Thompson

Attachment

Appendix B

DRAFT REPORT: Combined Assessment Program Review – VA Medical Center, Iron Mountain, MI (Project No. 2003-01387-R3-0087)

Date of Report: Draft Report dated June 11, 2003

Recommendations/Actions	Status	Completion Date

Recommendation Improvement Action 1: To improve management controls over controlled substance accountability, we recommend that the VISN Director require the Medical Center Director to ensure that:

a. Unusable controlled substances are destroyed quarterly.

Concur

Medical Center policy 119-3 "Controlled Substance Policy and Procedure" dated March 30, 2001, which references VHA Handbook 1108.1, mandates the quarterly destruction of controlled substances and assigns responsibility. To ensure that the local policy is followed a definitive schedule has been established for the quarterly controlled substance destruction and will be supervised by Chief, Pharmacy Service, with a confirmation report to the Associate Medical Center Director.

Completed April 2003

b. Medical center policies are revised to limit inspectors to 6 inspections within a 12-month period.

Concur

Medical Center policy 00-69 has been re-written as of June 29, 2003 and now specifies that no inspector may conduct more than 6 inspections within a 12-month period.

Completed June 2003

c. Unannounced inspections of controlled substances are conducted monthly.

Concur

Medical Center policy 00-69 mandates the unannounced monthly controlled substance inspections. To ensure that our local policy is followed, the Chief of Police as the coordinator will assure random monthly inspections of all areas.

Completed June 2003

Appendix B

d. Controlled substances inspectors conduct the physical count of controlled substances during inspections.

Concur

Medical Center policy 00-69, dated June 29, 2003, has been re-written to assure that inspectors conduct the physical count of controlled substances during inspections. Training materials for inspectors will be updated to reflect this requirement and all inspectors re-educated in the process. Nursing and Pharmacy staffs have been directed to be present during the inspection, but not to do any physical counts.

In Process September 2003

e. The inspection team is notified when prescriptions are filled during inspections.

Concur

To assure that the inspection team is notified when prescriptions are filled during the inspections, Iron Mountain will provide refresher training to the inspectors. In addition, reminders have been published to the pharmacy staff to notify inspectors of the need to fill a prescription during the inspection. The Chief, Pharmacy Service, will monitor this.

Completed June 2003

f. Discrepancies identified during the monthly inspections are reported to the Director.

Concur

Medical Center policy 00-69, dated June 29, 2003 outlines the monthly reporting responsibility and coordination of reports to the Director. The policy has been amended to include the language, "In cases of inaccuracy in balance of records, the inspecting official(s) will report the discrepancy to the accountable official who will determine the cause and a report of findings will be made to the facility Director, who will take indicated corrective action." The inspecting official will report any losses disclosed during the monthly inspections to the facility Director.

Completed June 2003

Appendix B

Recommended Improvement Action Item 2: To improve Automated Information System (AIS) Security, we recommend that the VISN Director require the Medical Center Director to ensure that:

a. The ISO is trained in the audit features of VISTA

Concur

Training on the VISTA audit features for the ISO began in May 2003 and is scheduled for completion by September 2003.

In Process September 2003

b. AIS Refresher training is provided to contract staff annually.

Concur

AIS refresher training has been completed for the identified contract staff. The ISO has established a monitoring system to assure that all contract staff requiring AIS access receive refresher training annually.

In Process July 2003

c. A contingency plan is developed for the contract CBOC

Concur

A new contract for the CBOC in Ironwood, MI has been signed. At the time of the CAP review inspectors reviewed the old contract for Ironwood CBOC. A contingency plan is in place with the new contract effective June 1, 2003.

Completed June 2003

d. Periodic follow up is conducted with the Officer of Personnel Security concerning the status of background investigations requested for employees working in sensitive positions.

Concur

The VISN 12 Human Resource product line has agreed to conduct queries to the Office of Personnel Management six months following the initial investigation request and quarterly thereafter, requesting the status of investigations for sensitive positions. The facility ISO will work with Human Resources to ensure receipt of this quarterly status report and will report to the Medical Center Director.

Completed June 2003

Appendix B

e. The ISO continues to monitor employee access to the medical records of other employees

Concur

The ISO has established a daily review and reporting mechanism to appropriate service chiefs or supervisors of employee records being inappropriately accessed by other employees for minor offenses. More serious offenses will result in prompt removal of access by the ISO and referral to the Medical Center Director for appropriate action.

Completed May 2003

f. Shared drive security levels are reset to restrict access to sensitive information to those having a need for the information

Concur

Shared drive security levels have been reset to restrict access to sensitive information to those having a need for the information. In addition, an operating procedure, "Creation of Shared Directories" was published May 27, 2003 to ensure compliance is maintained.

Completed May 2003

Recommended Improvement Action Item 3: To assure compliance with processing time for enrollment applications and appointment waiting times, we recommend that the VISN Director require the Medical Center Director to ensure that:

a. Enrollment applications are processed within 7 days of receipt.

Concur

To ensure applications are processed within 7 days of receipt, effective July 2003, a centralized check in (CCI) unit will be established. The CCI will determine eligibility on all applications and monitor processing to include tracking the time the application is received to assure completion within 7 days of receipt. The CCI will report weekly statistics on applications received, processed and timeliness to the Chief, Patient Administrative Service and Medical Center Director.

In Process September 2003

Appendix B

b. Appointments for new enrollees in primary care are scheduled within 180 days of the date the appointments are requested.

Concur

Prior to the CAP review, Iron Mountain had already requested and received approval for additional provider staff as the primary means to assure the timely scheduling of appointments. These staff are scheduled to be on duty by the end of September 2003. Once this staff is trained, we will be able to meet the 180-day time frame for scheduling primary care appointments. The Chief of Primary Care will monitor access and report monthly to the Medical Center Director.

In Process September 2003

Suggested Improvement Action Item 1: We suggest that the VISN Director require the Medical Center Director to ensure that:

a. Cardholders complete the reconciliation process for purchase card transactions before they are 30 days old.

Concur

Education on how to close partial orders was completed during May and June 2003. The backlog of 451 transactions, including 174 transactions over 180 days old has been corrected. The most recent check of 6/27/03 showed no transactions outstanding. There was no financial impact associated with this backlog. The Purchase Card coordinator has implemented a system to review the report at least twice monthly to assure no reconciliation over 30 days occur.

Completed June 2003

b. Approving officials certify purchase card transactions within 14 days after reconciliation.

Concur

Although the CAP team reviewed the transactions for a 16-month period ending 3/17/03, Iron Mountain had already identified and initiated corrective action during February 2003. Subsequent review in May 2003, showed 6 out of 2,305 transactions (or less than .002%) had not been approved within 14 days, which was reflected on the End of the Month Purchase Card Report submitted to VA Central Office on June 5, 2003. Therefore, although we concur with the suggestion, we believe that this had already been corrected. We will continue with our ongoing monitor process.

Completed May 2003

Appendix B

Suggested Improvement Action Item 2: We suggest that the VISN Director require the Medical Center Director implement procedures to:

a. Thoroughly analyze and trend pertinent QM data

Concur

Iron Mountain will establish a series of data analysis educational sessions. This training will be implemented as a mandatory training for all service chiefs and supervisors in FY 2004 and will focus on identifying patterns and trends. In addition, the Quality Council will be the oversight of service quality management data. For example, effective with 4th quarter, FY 2003, the Patient Representative will collect all patient complaints and aggregate them by provider, service location and nature of complaint, along with action taken for improvements. Complaints requiring immediately action will be referred to the supervisor. This data will be reported quarterly to the Quality Council, with the first reporting to be in October 2003 on 4th quarter FY 2003 data.

In Process March 2004

b. Document corrective action plans and their effectiveness in meeting measurable goals.

Concur

A mandatory format for meeting minutes is being developed and will be implemented by all services and committees. This format will provide a structure for service chiefs and supervisors to identify issues, action plans, responsible party and timelines. Education and training will be provided to appropriate individuals to explain use of this new format and their role to assure appropriate follow up and documentation in meeting minutes.

In Process July 2003

Appendix C

Report Distribution

VA Distribution

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Veterans Integrated Service Network Director (10N12)
Director, VA Medical Center Iron Mountain, MI (585/00)

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- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Governmental Reform, U.S. House of Representatives
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations,

Appendix C

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

This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.