Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Muskogee VA Medical Center Muskogee, Oklahoma

Report No. 03-02374-017 **November 7, 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 agency 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.

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of August 18–22, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Muskogee VA Medical Center, which is part of Veterans Integrated Service Network (VISN) 16. 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 also provided fraud and integrity awareness training to 98 medical center employees.

Results of Review

The medical center's program to review the effectiveness of cardiopulmonary resuscitation was comprehensive. The pharmacy had effective access controls and physical security. Oversight of part-time physician time and attendance was satisfactory. Our review of service contracts found no significant deficiencies. To improve operations, the medical center needed to:

- Correct deficiencies and strengthen controls in controlled substances accountability.
- Complete inventories of nonexpendable equipment and update inventory records.
- Reduce excess medical, engineering, and prosthetic supply inventories and strengthen inventory management controls.
- Ensure that community nursing home contracts are properly negotiated.
- Improve procedures for identifying veterans with insurance and pursue insurance receivables more aggressively.
- Enhance QM by improving the consistency of data analysis, documentation of corrective actions, and use of evaluation criteria.
- Strengthen controls and correct security deficiencies for information technology resources.
- Follow up on deficiencies identified during community nursing home inspections.

VISN 16 and Muskogee VA Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes B and C, pages 15-23, for the full text of the Directors' comments.) We will follow up on planned actions until they are complete. This report was prepared under the direction of Ms. Claire McDonald, CAP Review Coordinator, Seattle Audit Operations Division.

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

Introduction

Medical Center Profile

Organization. The Muskogee VA Medical Center is a general medical and surgical facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics (CBOCs) in Tulsa and McAlester, OK. The medical center serves a population of over 145,000 veterans in a primary service area that includes 25 counties in Oklahoma.

Workload. In Fiscal Year (FY) 2002, the medical center treated 27,804 unique veterans, a 9 percent increase from FY 2001. Medical center management attributed the increase in unique veterans treated to the continuing retiree population growth in the area, local industry layoffs, and the increasing number of veterans who are turning to VA for most of their medical care in order to use VA pharmacy benefits. The FY 2002 inpatient average daily census (ADC) was 42.3. For FY 2003 through July 2003, the ADC was 47.6. Outpatient care workload totaled 244,647 patient visits in FY 2002 (a 14 percent increase from FY 2001) and 210,637 visits in FY 2003 through July 2003.

Resources. The medical center's FY 2003 medical care budget was $84.1 million, a 17 percent increase over the FY 2002 budget of $72.0 million. FY 2003 staffing through July 2003 was 623.6 full-time equivalent employees (FTEE), including 41.5 physician and 163.2 nursing FTEE. FY 2002 staffing was 617.8 FTEE, including 38.9 physician and 163.2 nursing FTEE.

Programs. The medical center provides medical, surgical, and mental health services. The medical center has 50 hospital beds and operates special programs for alcohol and drug treatment, respite care, and women's health. Specialty clinics include cardiology, gastroenterology, oncology, orthopedics, and optometry.

Affiliations. The medical center is affiliated with the University of Oklahoma College of Medicine and supports two family practice medical resident positions. The medical center is also affiliated with several schools to provide clinical training opportunities for nursing, dental, pharmacy, physical therapy, and optometry students.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care 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 of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FY 2002 and FY 2003 through August 2003 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 15 activities:

- Community Nursing Home Program
- Community Residential Care Program
- Controlled Substances Accountability
- Enrollment and Resource Utilization
- Environment of Care
- Equipment Accountability
- Information Technology Security
- Laboratory Security
- Medical Care Collections Fund
- Part-Time Physician Time and Attendance
- Pharmaceutical Cache
- Pharmacy Security
- Quality Management
- Service Contracts
- Supply Inventory Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–13). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, 114 of whom responded. We also interviewed 31 patients during the review. The survey and interview results were discussed with the Medical Center Director.

During the review, we also presented 4 fraud and integrity awareness briefings that were attended by 98 medical center employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Organizational Strengths

The Review of Outcomes from Cardiopulmonary Resuscitation Was Comprehensive. The medical center had established a comprehensive program to review the effectiveness of cardiopulmonary resuscitation through use of national and local performance measures. Data collected included number of events, time of occurrence, duration, location, diagnosis, and survival after the immediate event and at discharge. Program managers displayed the data graphically to show trends, and managers implemented improvement actions based on the analyzed data.

Pharmacy Access Controls and Security Were Effective. To control access to the pharmacy, the medical center used an electronic fingerprint recognition system that allowed employee access to be set up for specific days and shifts. Additional fingerprint recognition systems were installed on the controlled substances vaults located in the pharmacy. Closed circuit cameras also monitored the areas. The Chief of Pharmacy Service routinely verified access to the controlled substances vault to ensure that no more than 10 pharmacy employees had access during a 24-hour period and that access was promptly terminated when employees no longer required it.

Part-Time Physician Time and Attendance Controls Were Effective. Fiscal Service had established effective procedures for verifying time and attendance of the medical center's seven part-time physicians. Fiscal Service had also developed an in-depth process for auditing time and attendance that included reviews of physician time and leave records, clinic and procedure schedules, and patient records. Audits of timekeeping controls were conducted at least every other pay period, and results were reported to the Chief of Staff. Timekeepers were trained on applicable time and attendance policies, and all of the part-time physicians had received and acknowledged notification of these policies.

Opportunities for Improvement

Controlled Substances Accountability – Deficiencies Should Be Corrected and Controls Strengthened

Conditions Needing Improvement. We reviewed pharmacy security and controlled substances accountability to determine if controls were adequate to prevent the loss or diversion of drugs and to ensure that controlled substances were properly accounted for. Although pharmacy access controls and pharmacy security were effective, we found eight deficiencies in pharmacy administration practices and controlled substances inspection procedures as discussed below.

Pharmacy Administration. Veterans Health Administration (VHA) policy requires that medical facilities maintain a perpetual inventory of all pharmacy stock of controlled substances and that pharmacy staff verify the inventory at a minimum of every 72 hours. In addition, at least quarterly, the pharmacy is required to turn in expired, excess, and unusable controlled substances for destruction. These unusable items should be recorded on the medical center's Unusable Controlled Substances Ledger. We identified two pharmacy administration deficiencies.

- Pharmacy staff were not conducting inventories of controlled substances every 72 hours. Instead, they conducted the inventories every Tuesday and Friday. This resulted in a 96-hour span between the Friday and the following Tuesday inventories.

- Pharmacy staff did not ensure that expired, excess, and unusable controlled substances were destroyed quarterly. During the 12-month period September 2002–August 2003, these drugs were destroyed only twice, in September 2002 and May 2003.

Controlled Substances Inspections. VHA policy requires medical facilities to conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period September 2002–August 2003, interviewed inspectors, and observed unannounced inspections of selected areas where controlled substances were stored and dispensed. We identified six inspection deficiencies.

- Inspection practices did not ensure that all controlled substances storage locations were inspected every month. During the review period, 50 of the 164 required inspections (31 percent) were not performed. In addition, seven locations were not inspected during the 3-month period September–November 2002 and again during the 3-month period January–March 2003.

- Inspectors did not count all controlled substances in pharmacy stock. Medical center policy requires all controlled substances inventories to be certified by actual count or measure. During an OIG-observed inspection, the inspector did not consistently count pills in unsealed medication bottles. Instead, he relied on counts that pharmacy staff had previously recorded on the bottle labels.

- Inspectors did not verify that pharmacy staff were conducting the VHA-required 72-hour controlled substances inventories.

- Inspectors did not count all expired, excess, and unusable controlled substances. During an OIG-observed inspection, the inspector did not verify the quantities of these controlled substances stored in the vault with the quantities reported in the Unusable Controlled Substances Ledger.

- Inspectors did not compare receiving reports and vendor invoices with pharmacy stock inventory records to verify the quantities of controlled substances received into stock.

- Inspectors did not randomly select ward dispensing entries and compare them with patient records to verify that the controlled substances removed from inventory were properly supported by medication orders and drug administration records.

In July 2003, the medical center issued a new inspection policy that included a detailed checklist incorporating the VHA-required procedures. We observed three newly appointed inspectors who were not consistently following this checklist. The Controlled Substances Inspection Coordinator acknowledged that the inspectors needed additional supervised practice in inspections and stated that an inspection team leader would observe future inspections and provide on-the-job training and guidance to inspectors until they are all fully proficient.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to require that: (a) 72-hour inventories are conducted in accordance with VHA policy; (b) expired, excess, and unusable controlled substances are destroyed quarterly; and (c) controlled substances inspectors follow all VHA and medical center policies and procedures for conducting inspections.

The VISN and Medical Center Directors agreed with the recommendations and reported that as of October 2003 Pharmacy Standard Operating Procedures had been updated to emphasize that inventories be conducted every 72 hours. As of October 2003, the medical center had also developed plans to ensure that expired, excess, and unusable controlled substances are destroyed quarterly. In addition, medical center management had implemented procedures to ensure that controlled substances inspectors follow all VHA and medical center policies for conducting inspections. The target date for full implementation is October 31, 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Equipment Accountability – Inventories Should Be Done and Equipment Inventory Lists Updated

Conditions Needing Improvement. Medical center management needed to improve policies and procedures to ensure that nonexpendable equipment (items costing more than $300 with an expected useful life of more than 2 years) is properly safeguarded and accounted for. To determine if equipment accountability was adequate, we reviewed equipment inventory records

and a judgmental sample of 30 equipment items. We identified four deficiencies that required corrective action.

Local Policies and Procedures. Although the Chief of Acquisition and Materiel Management Service (A&MMS) had recently developed an equipment accountability policy, this policy was not sufficiently detailed and had not been adequately implemented in areas such as equipment accounting requirements, loan of property, physical inventories, and reporting lost or damaged equipment. The Chief of A&MMS acknowledged these omissions and began actions to strengthen and fully implement the policy during our review.

Timeliness of Inventories. VA policy requires that periodic inventories be performed to ensure that equipment is properly accounted for and recorded in accountability records called equipment inventory lists (EILs). For EILs with fewer than 100 line items, required inventories should be completed within 10 days of notification that the inventory is due. As of August 2003, the medical center had 60 EILs (1,219 line items; value = $20.4 million), all with fewer than 100 items. We found that only 11 of the 60 (18 percent) inventories for FY 2003 had been completed, even though the accountable service officials had been notified of the inventories in January 2003 and none had requested extensions.

Accuracy of EILs. To verify the accuracy of information on the EILs, we reviewed a judgmental sample of 30 items assigned to 20 EILs (combined value of the 30 items = $674,884). The EILs were inaccurate for 22 of the 30 items (73 percent). Sixteen of the 22 items had been either transferred to other services or moved within the services, but the EILs did not reflect the current locations. Three items (computers valued at about $4,500) could not be located during our review. The remaining three items had been excessed but not removed from the EILs.

Reporting Equipment Loss or Damage. VA policy requires that employees submit a Report of Survey form to A&MMS when equipment is lost, damaged, or destroyed. The purpose of the form is to document the circumstances of the loss or damage, affix responsibility, record pecuniary liability, and support the removal of the item from the EIL. Medical center staff were not timely in meeting this requirement. For example, in May 2003 the Chief of Information Resources Management submitted a Report of Survey to A&MMS for lost computer equipment that he had reported to the VA Police approximately 9 months earlier. During our review he submitted two more Reports of Survey for computer equipment that had been lost in January 2002, almost 20 months earlier. (As of October 2003, these computer equipment losses were under investigation.)

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) the Chief of A&MMS to write and implement a detailed medical center equipment accountability policy; (b) EIL holders to complete timely inventories and A&MMS staff to verify EILs; (c) EIL holders to update EILs when equipment is moved or excessed; and (d) medical center staff to promptly submit Reports of Survey when equipment is lost, damaged, or destroyed.

The VISN and Medical Center Directors agreed with our recommendations and stated that by November 2003 a revised equipment accountability policy would be published and that all

employees would be trained on the requirements. In addition, medical center management developed a process to ensure that EIL inventories were completed by October 2003 and that a reminder system is implemented for subsequent inventories. As of October 2003, management had also implemented procedures for updating EILs when equipment is moved or excessed and for training staff to promptly submit Reports of Survey when equipment is lost, damaged, or destroyed. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Conditions Needing Improvement. The medical center needed to reduce excess inventories of medical, engineering, and prosthetic supplies and make better use of automated controls to more effectively manage supply inventories. In FY 2002, the medical center spent $2.9 million on medical, engineering, and prosthetic supplies. The VHA Inventory Management Handbook establishes a 30-days or less supply inventory goal and requires that medical centers use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Medical Supplies. A&MMS staff used GIP to manage medical supply inventory. However, they were not fully using GIP features to meet the inventory goal of 30 days or less. As of July 2003, the A&MMS medical supply inventory consisted of 1,367 items with a stated value of $1,102,993.

To test the accuracy of inventory valuation and the reasonableness of inventory levels, we reviewed a judgmental sample of 20 medical supply items and found 2 deficiencies. First, the GIP value of stock was overstated. For the 20 stock items reviewed, the GIP-reported value was $207,656. The actual value of this stock was $39,392, which was only 19 percent of the GIP-reported value. Applying the 19 percent figure to the $1,102,993 value for the entire medical supply stock shown in GIP would yield an estimated value of $209,569.

Second, stock on hand exceeded 30 days. Only 1 of the 20 items was under the 30-day stock level. Eight of the 20 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 67 days to 35 years of supply. The estimated value of stock exceeding 30 days for these 8 items was $22,174, or 56 percent of the total value of the 20 items. For the remaining 11 items, we could not determine if stock exceeded the 30-days or less standard because when A&MMS staff removed items from inventory they did not record this action in GIP. Therefore, usage histories for these items were not reported in GIP.

The excess stock and inaccuracies in GIP occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-days or less standard. Because the GIP data was inaccurate, we could not precisely determine the value of stock on hand or the value of excess stock for the entire inventory. However, by applying the

56 percent of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock was about $117,987 (56 percent x $209,569 estimated value of stock).

Engineering Supplies. Facilities Management Service (FMS) did not use GIP or any other formal method to manage engineering supply inventory. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgmental sample of 10 high-use engineering supply items (value = $1,170). Because FMS did not use GIP, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-days or less goal for all 10 items, with inventory levels ranging from 90 to 255 days of supply (excess value = $772). Without sufficient inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded current needs. The Chief of FMS acknowledged the need to reduce the inventory and to develop a comprehensive plan for controlling supplies with GIP.

Prosthetic Supplies. Prosthetic Sensory Aids Service (PSAS) staff used VA's Prosthetics Inventory Package (PIP) automated system to control inventory. However, they were not fully using PIP features to meet the inventory goal of 30 days or less. The PSAS maintained a supply inventory of 224 items valued at $10,990.

To determine the accuracy of PIP-reported information and the reasonableness of inventory levels, we reviewed a judgmental sample of 10 items and found 2 deficiencies. First, the PIP inventory value of stock was understated. For the 10 items reviewed, the PIP-reported value was $1,471. The actual value of this stock was $4,080, which was 277 percent more than the PIP-reported value ($4,080 ÷ $1,471). Applying the 277 percent figure to the $10,990 value for the entire prosthetic stock shown in PIP would yield an estimated value of $30,486.

Second, 6 of the 10 sampled items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 40 to 570 days of supply. The estimated value of stock exceeding 30 days was $2,747, or 67 percent of the $4,080 total value for the 10 items. Excess inventory occurred because PSAS staff were not properly monitoring PIP and were not adjusting stock levels to reflect actual usage rates. By applying the 67 percent estimate of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock was about $20,517 (67 percent x $30,486 estimated PIP value of stock).

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) A&MMS to reduce medical supply inventory and improve the accuracy of GIP data, (b) FMS to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP, and (c) PSAS to reduce excess prosthetic inventory and improve the accuracy of PIP data.

The VISN and Medical Center Directors agreed with our recommendations and reported that plans had been developed to monitor usage rates, perform wall-to-wall physical inventories, and conduct quarterly spot checks of medical supply inventory by December 2003. In addition, FMS staff had developed and implemented plans to use GIP for controlling engineering supplies and to reduce engineering supply inventory by January 2004. For prosthetic supplies, plans had been developed to complete a wall-to-wall physical inventory, correct inaccuracies in PIP, and dispose

of excess inventory items by November 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Community Nursing Home Contracts – Contract Negotiations Should Be Improved

Conditions Needing Improvement. VHA permits medical facilities to contract for community nursing home care to provide VA patients a greater choice of nursing homes in close proximity to their homes and families. Contracting officers are required to negotiate fair and reasonable prices for nursing home care and document these negotiations in the contract file. As of August 2003, the medical center had 17 nursing home contracts (estimated annual cost = $1.6 million) to provide care for VA patients through its Community Nursing Home (CNH) Program.

We reviewed all 17 contracts to determine if they had been adequately negotiated and if the negotiations were properly documented in Price Negotiation Memorandums (PNMs). None of the contracts had been adequately negotiated. The medical center paid the maximum nursing home care rates allowed and did not attempt to negotiate lower prices. In addition, just 1 of the 17 contract files contained a PNM, which only stated that the medical center could not pay more than the authorized VA rates. According to the Chief of A&MMS, contracting officers had not been negotiating contract prices with nursing homes for several years. Instead, in the contract solicitations they informed the nursing homes of the Medicaid rate plus the authorized percentage VA would pay for various levels of care. The Chief of A&MMS agreed that this practice should be discontinued and that contracts should be properly negotiated. Further, she initiated a policy to ensure that negotiations for all nursing home contracts would start at the Medicaid rate.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires contracting officers to: (a) negotiate fair and reasonable prices for nursing home contracts and (b) properly document negotiations in the contract files.

The VISN and Medical Center Directors agreed with our suggestions and stated that as of October 2003 procedures had been implemented to ensure that nursing home contracts are properly negotiated and that negotiations are adequately documented in the contract files. The improvement actions are acceptable, and we consider the issues resolved.

Medical Care Collections Fund – Better Identification of Insured Veterans and Stronger Follow-Up Would Increase Collections

Conditions Needing Improvement. Medical center management needed to improve procedures for identifying veterans with insurance coverage and to more aggressively pursue accounts receivable from insurers. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain veterans who have insurance. Successful recovery of costs requires that medical center staff accurately identify veterans with insurance, promptly bill insurance companies, and aggressively follow up on

insurance receivables. Although staff were promptly billing insurance companies, they were not consistently identifying veterans with insurance and aggressively following up on outstanding receivables.

Identification of Insurance Coverage. Medical center policy requires that insurance information be obtained at the time of treatment. Clinic staff should ask veterans if they have insurance or if their coverage has changed and obtain copies of the veterans' insurance cards. To determine if clinic staff obtained the necessary information, we observed check-in and check-out procedures in five clinics. None of the staff we observed inquired about insurance coverage. Clinic staff and managers stated that they were aware of the requirement to obtain insurance information, but they could not explain why this was not done.

Follow Up on Receivables. As of July 10, 2003, the medical center had 9,820 outstanding insurance bills with a total value of about $2.1 million (excluding receivables that had been referred to the VA Regional Counsel for collection). Of these receivables, 2,855 with a value of about $747,551 (35 percent of the total value) were more than 90 days old. To evaluate medical center collection efforts, we reviewed a judgmental sample of 50 receivables (value = $40,982) that had been outstanding for more than 90 days. Based on our review and discussions with the Business Office Manager, we determined that 30 receivables (value = $22,206) required more aggressive follow-up action. MCCF staff had sent original bills and collection letters but had not routinely made follow-up telephone calls to determine why payment had not been made.

For FY 2003, the medical center's collection rate for insurance receivables was about 45 percent. This rate reflects the fact that insurance companies typically do not pay 100 percent of the amount billed. Based on this rate, the medical center should collect about $338,640 ($747,551 x 45 percent) of the receivables that were over 90 days old. In addition, after further discussions with the Business Office Manager, we believe that if the medical center pursued MCCF receivables more aggressively, the collections would increase by at least another 5 percent, or about $16,932 (5 percent x $338,640).

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director implements procedures to: (a) obtain and update veteran insurance information at the time of treatment and (b) pursue MCCF receivables more aggressively.

The VISN and Medical Center Directors agreed with our suggestions and reported that as of October 2003 procedures had been implemented to ensure that veteran insurance information is obtained at the time of treatment and that MCCF receivables are more aggressively pursued. The improvement actions are acceptable, and we consider the issues resolved.

Quality Management – Better Data Analysis, Action Identification, and Use of Evaluation Criteria Would Strengthen the QM Program

Conditions Needing Improvement. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, reports, credentialing and privileging files, performance improvement data, and other pertinent documents. We concluded

that the program was comprehensive and generally provided appropriate oversight of patient care. Data was collected in all areas required by accreditation standards but was not consistently critically analyzed. In addition, program managers did not consistently assign time frames for action items or document how the effectiveness of the actions would be evaluated.

Data Analysis. The medical center's analysis of continued stay appropriateness stated there were no trends; however, only 65 percent of the cases met established criteria. Based on utilization review (UR) minutes, the UR staff did not document a trend that we identified from these minutes during our review. VHA policies and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require critical analysis of utilization review data.

Action Identification. When data indicated that goals were not met, program managers did not always identify corrective actions. For example, when deficiencies were noted for a lack of physician signatures on histories and physical examinations, the Medical Records Committee stated that they would continue to monitor for physician signatures but did not document a corrective action. In those cases where corrective actions were identified, managers did not consistently assign time frames for implementation. As a result, QM staff did not have a tracking mechanism to monitor completion of action items, which made it difficult to monitor the effectiveness of recommendations to improve patient care. QM staff agreed that adding a due date column on committee meeting minutes would remind program managers to assign time frames for corrective actions and changed the form before the end of our review.

Evaluation Criteria. Program managers had identified criteria for determining whether corrective actions were effective in areas such as operative and invasive procedure reviews and root cause analyses. However, they needed to identify methods to evaluate effectiveness for all other areas of quality review, as required by JCAHO.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director implements procedures to: (a) consistently critically analyze QM data and identify opportunities to improve the quality of patient care, (b) establish procedures to monitor the implementation of recommendations from QM reviews, and (c) define evaluation criteria for identified corrective actions.

The VISN and Medical Center Directors agreed with our suggestions and stated that in November 2003 all service chiefs, committee chairs, and supervisors would receive mandatory training on data analysis. In addition, medical center management has established procedures for monitoring the implementation of QM recommendations and defining evaluation criteria for corrective actions. In November 2003, each QM-related committee will begin reporting on the effectiveness of corrective actions. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Controls Need To Be Strengthened

Conditions Needing Improvement. We reviewed medical center information technology (IT) security to determine if controls were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Critical data was regularly backed up and properly stored off-site, and an alternate processing facility had been established. However, we identified four IT security issues that required corrective action.

System Access. VHA policy requires that facilities review Veterans Health Information Systems and Technology Architecture (VISTA) user access and privileges at least every 90 days for appropriate levels of access or continued need. Working with the Information Security Officer (ISO), we reviewed a judgmental sample of 40 accounts and concluded that user access should have been terminated for 11 accounts (4 former medical center and 7 former contract employees). The 11 users never logged onto the system. As a result, VISTA did not identify them, and the ISO did not remove them from the system.

IT Security Training. VA policy requires that every employee, contractor employee, and volunteer who manages or uses VA computer systems receive at least 1 hour of computer security awareness training each year. The ISO had documentation to show that all medical center employees received the training. She also had certificates of training for some contractors and volunteers; however, she did not have documentation of training for all computer system users. As a result, she did not know if all users had met the training requirement. The ISO started corrective action during our review.

Segregation of Duties. VHA policy requires that each medical center establish a policy to ensure that IT duties are separated so that a single employee cannot bypass system controls. We determined that the medical center had not established this policy. The ISO developed a policy before the end of our review.

Contingency Plan. The McAlester CBOC was not included in the medical center's IT contingency plan or during testing of the plan. When we informed medical center management of this oversight, they immediately revised the contingency plan to include the CBOC.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires: (a) VISTA access be promptly terminated for all individuals who do not have a continued need for access and (b) all system users receive annual computer security awareness training.

The VISN and Medical Center Directors agreed with our suggestions and reported that as of September 2003 procedures had been implemented to ensure that VISTA access is promptly terminated for all individuals who do not have a continued need for access and that all system users receive required computer security awareness training. The improvement actions are acceptable, and we consider the issues resolved.

Community Nursing Home Program – Follow-Up on Deficiencies Should Be Improved

Condition Needing Improvement. The CNH Program is designed to assist veterans and their families in making the transition from VA medical centers, nursing homes, or domiciliaries to contracted nursing homes in the community. To ensure quality of care and compliance with contract terms, members of the medical center's CNH evaluation team inspect the homes monthly and identify deficiencies requiring corrective action. The evaluation team can also recommend the approval, disapproval, or termination of CNH contracts.

Based on our discussions with the leader of the nursing home inspection team, we found that inspectors did not routinely follow up on deficiencies identified during previous reviews, except in cases that warranted immediate suspension of veteran placement into the CNH. As a result, the inspectors had no assurance that all previously identified deficiencies had been corrected. In cases of continued uncorrected deficiencies, the medical center should consider suspending placement of veterans into the CNH or terminating the contract altogether. The Chief of Patient Care Services agreed that consistent follow-up on cited deficiencies would enhance the CNH Program and ensure quality of care for veterans in CNHs.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director implements procedures to follow-up on all deficiencies identified during monthly community nursing home inspections.

The VISN and Medical Center Directors agreed with our suggestion and reported that the medical center's Long Term Care Committee, established in August 2003, had begun maintaining a log of issues and corrective actions. The improvement action is acceptable, and we consider the issue resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
3 a, c	Better use of funds by reducing excess medical and prosthetic supply inventories.	$138,504
N/A	Better use of funds through improved collection of MCCF accounts receivable.	$16,932
	Total	$155,436

Appendix B

VISN 16 Director Comments

Department of Veterans Affairs

Memorandum

Date: October 20, 2003

From: Network Director (10N16), South Central VA Health Care Network (SCVAHCN)

Subj: OIG Combined Assessment Draft Report (CAP), VAMC, Muskogee, OK (Project No. 2003-02374-R8-0132), Facility Responses to Recommendations

To: Assistant Inspector General for Auditing (52)

1. The SCVAHCN 16 has reviewed the changes included in the Draft CAP Report for the VA Medical Center, Muskogee, Oklahoma, and concur. However, as per your email dated October 16, 2003, if management does not concur with these changes, we would request the opportunity to revise our responses.

2. If you have questions or need additional information, please contact Ms. Melinda Murphy, Center Director, VAMC, Muskogee, at 918.680.3644.

Original signed by Susan Pendergrass on behalf of:
Robert Lynch, M.D.

Attachment

Appendix C

Muskogee VA Medical Center
Director Comments

Department of Veterans Affairs

Memorandum

Date: October 20, 2003

From: Medical Center Director, VAMC Muskogee, OK (623)

Subj: Response, Office of Inspector General CAP Report

To: Assistant Inspector General for Auditing (52)
Thru: Director, South Central VA Health Care Network (10N16)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program draft report of its review of the Muskogee VA Medical Center. Specific comments are included with the implementation plan that is attached to this memorandum.

2. I am pleased with the outcome of the review in that it provided additional confirmation that Muskogee VA Medical Center is meeting its goals of providing high quality of care to veterans in a way that garners a high level of patient satisfaction. Also important is the high level of employee satisfaction noted by the audit team. It is gratifying that many of the opportunities for improvement were of a type that could be fully addressed during the time the audit team was on site and the remainder can be completed within the next few months.

3. Please express my appreciation to the team members who conducted the CAP review during the week of August 18, 2003 for their assistance and professionalism. If you have any questions about the comments or implementation plan, please do not hesitate to call me.

Original signed by:
M.L. Murphy

Appendix C

MUSKOGEE VA MEDICAL CENTER
Comments and Implementation Plan

1. Controlled Substances Accountability – Deficiencies Should Be Corrected and Controls Strengthened

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the medical center Director takes action to require that: (a) 72-hour inventories are conducted in accordance with VHA policy; (b) expired, excess, and unusable controlled substances are destroyed quarterly; and (c) controlled substances inspectors follow all VHA and medical center policies and procedures for conducting inspections.

a. 72 Hour Inventories

Concur with recommended improvement actions:
Pharmacy Standard Operating Procedure (SOP) was modified and implemented to require 72-hour inventories be performed. VHA Handbook 1108.2 published on August 29, 2003, requires inpatient vault to be inspected three times per week and the outpatient vaults to be inventoried twice per week. Changes consistent with this requirement were made to the SOP and implemented in September 2003. Adherence to requirements will be confirmed by the Narcotics Inspectors and recorded in their reports through the Controlled Substances Inspection Coordinator on a monthly basis. A monthly calendar will be submitted to the Director that documents the days on which inspections in each of the vaults occurred.

Target date: Inventory changes – Completed
Monthly calendar – Begin October 2003

b. Destroy expired, excess, and unusable controlled substances quarterly

Concur with recommended improvement actions:
This has been corrected and confirmed as such by the Controlled Substances Inspection Coordinator (CSIC). Each month, Narcotics inspectors will include a check for this in their Pharmacy inspections. They will document whether narcotics were sent for destruction. If there are narcotics to be sent, the inspectors will compare the items awaiting destruction with the Unusable Controlled Substances Ledger and document whether the two reconcile. The Controlled Substances Inspection Coordinator will monitor the reports for confirmation that destruction on at least a quarterly basis is occurring. It is expected that narcotics will be sent for destruction by at least the end of the second month of each quarter. Should two months of any quarter pass without destruction being documented, the CSIC will personally contact the Chief Pharmacy to assure destruction occurs and will advise the Director of such contact in the monthly report. Dates on which narcotics are sent for destruction will be annotated on the monthly calendar referenced in a. above.

Target date: Destruction – Completed and Ongoing
Monthly calendar – Begin October 2003

c. Controlled substances inspectors follow policies and procedures

Concur with recommended improvement actions:
The observed narcotic inspectors were newly appointed and had completed one didactic classroom training session at the time they were observed. After the classroom session,

inspectors have supervised practice in inspection by the team leader to assure their proficiency. Inspectors use a checklist to assure they comply with the policies and procedures. The team leader and Controlled Substances Inspection Coordinator will continue to review the checklist with each inspector post-inspection, provide and document targeted training as needed and refresher training at least semi-annually. Training will be documented on the monthly calendar referenced in a. above as part of the monthly reports to the Director.

Target date: Inspection procedures – Completed and Ongoing
Monthly calendar – Begin October 2003

VHA Handbook 1108.2 published on August 29, 2003 necessitates changes to the current medical center memorandum (MCM). Revision is underway. Education and training on the new MCM will take place once it is published.

Target date: October 31, 2003

2. Equipment Accountability – Inventories Should Be Done and Equipment Inventory Lists Updated

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the medical center Director requires: (a) the Chief of A&MMS to write and implement a detailed medical center equipment accountability policy; (b) EIL holders to complete timely inventories and A&MMS staff to verify EILs; (c) EIL holders to update EILs when equipment is moved or excessed; and (d) medical center staff to promptly submit Reports of Survey when equipment is lost, damaged, or destroyed.

a. Chief of A&MMS write and implement detailed equipment accountability policy

Concur with recommended improvement action:
A revised, equipment accountability policy will be published that incorporates the requirements in the existing guidebook. The Equipment Guidebook and the policy will be used to educate staff.

Target date:Revised policy published & staff educated – November 2003

b. EIL holders complete inventories and A&MMS verify EILs

Concur with recommended improvement action:
A process is in place to assure completion of EILs in October 2003. In addition, the process will be further refined to include a reminder system to assure timely completion in subsequent years. Regardless of EIL accuracy, and the attendant review requirements, all will be reviewed no less than annually for the next three years to assure that we have an established and dependable system in place. Also, this will be a subject of discussion between the Chief, A&MMS and the Associate Director at least monthly in standing meetings until this action is complete.

Target date: EIL holders complete inventories - October 2003
A&MMS verify EILs and further refine processes – November 2003

c. EIL holders update EILs when equipment moved or excessed

Concur with recommended improvement action:
Updated equipment location is being checked by EIL holders during October EIL inventories as discussed in 1b above. A&MMS staff will conduct quarterly spot checks of equipment in each service, focusing on equipment most often moved, to verify EILs are updated. Depending on the

findings during spot checks, checks may occur more frequently than quarterly.

Target date:EIL Holders Update Equipment Location – October 2003
Quarterly spot checks of equipment EILs beginning October 2003

d. Medical center staff promptly submit Reports of Survey when equipment lost, damaged or destroyed.

Concur with recommended improvement action:
A Report of Survey electronic education tool and the Report of Survey Form were added to the facility website in August 2003, for training and easy access to the form to facilitate prompt reporting of lost, damaged or destroyed government property.

Formal mandatory training of Reports of Survey (RoS) to all Service Chiefs will be completed NLT 10/31/03. Associate Director will assure all Uniform Offense Reports (UOR's) on lost, damaged or destroyed equipment are forwarded to the Chief A&MMS. Completion of all EILs (noted in 2. b.) also will facilitate the Report of Survey process. Delinquent reports will occasion appropriate supervisory actions.

Target date: Education tool and RoS Form posted to website – Complete
Copies of UORs to A&MMS – Immediately
Formal training of all Service Chiefs – October 2003

3. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the medical center Director requires: (a) A&MMS to reduce medical supply inventory and improve the accuracy of GIP data, (b) FMS to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP, and (c) PSAS to reduce excess prosthetic inventory and improve the accuracy of PIP data.

a. A&MMS reduce medical supply inventory & improve accuracy of GIP data

Concur with recommended improvement action:
Wall-to-wall physical inventory of primary in SPD complete. Excess inventory items and item valuation reviewed. Both valuation and excesses in some cases is related to inaccurate inventory records; (e.g., the item identified as 35 year supply is water pitchers and both the packaging and costs per package were in error). To address this, days of stock will be monitored weekly and reviewed in a standing meeting with the Associate Director at least monthly until the Chief and AD are satisfied that stock and value are accurate and representative of facility need. Surgery wall-to-wall physical inventory with excess inventory items reviewed will be completed November 2003. The approach to verifying stock levels and valuation will mirror that of SPD supplies. Secondary inventories will be implemented with verification of items by services to be completed NLT 12-31-03 in accordance with the DUSHOM memorandum dated July 1, 2003. Quarterly spot checks by Chief A&MMS will be completed on a minimum of 10 items randomly selected in order to verify accuracy and review any excess inventory items. Dependent on the findings during spot checks, checks may occur more frequently than quarterly.

Target dates:SPD Primary inventory – complete
Quarterly spot checks – Begin October 2003
Complete correction of stock levels and values – November 2003
Surgery wall-to-wall inventory – November 2003
Secondary inventories implemented – December 2003

b. FMS reduce excess engineering supply inventory & develop comprehensive plan for controlling supplies with GIP

Concur with recommended improvement action:
Facilities Management Service (FMS) is proceeding with implementation of the GIP program begun earlier in the year. Staff with specific FMS GIP responsibility is in place. GIP will be used to manage the receipt, distribution, and maintenance of materials/supplies utilized by FMS throughout the medical center. To reduce inventories greater than 30 days, days of stock will be monitored weekly and reviewed in a standing meeting with the Associate Director at least monthly until the Chief and AD are satisfied that value, stock and controls are accurate, representative of facility need and adequate respectively. Of note, the inventory item with 255 days of supply was 17 one-half inch ball valves. The facility believes it has greater opportunity for inventory control in other items. FMS has established the Primary Inventory for receipt of supplies from A&MM warehouse and distributes these supplies to subordinate secondary inventory points. FMS is establishing Secondary Inventory points from the primary inventory point. Quarterly random spot checks by Chief FMS will be completed on a minimum of 10 items in order to verify accuracy and make any needed change to inventory levels/value, etc.. Dependent on the findings during spot checks, checks may occur more frequently than quarterly.

Target date: Establish Primary Inventory – Complete October 2003
Conduct random spot checks – Begin October 2003
Establish Secondary Inventory Points – December 2003
Reduce all inventories to less than 30 days – January 2004

c. PSAS reduce excess prosthetic inventory & improve accuracy of PIP data

Concur with recommended improvement action:
Wall-to-wall physical inventory of prosthetics primaries, correction to valuations, and disposal of any excess inventory items will be complete by mid-November. Secondary inventories will be completed by 12-31-03. Days of stock will be monitored weekly and reviewed in a standing meeting with the Associate Director at least monthly until the Chief and AD are satisfied that stock and value are accurate and representative of facility need. Quarterly random spot checks by the Chief A&MMS of a minimum of 10 items will begin in November. Dependent on the findings during spot checks, checks may occur more frequently than quarterly.

Target dates: Primary and excess inventory items addressed – November 2003
Complete correct valuation of inventory items – November 2003
Quarterly spot checks – Begin November 2003
Secondary inventories complete – December 2003

Community Nursing Home Contracts – Contract Negotiations Should Be Improved

Suggested Improvement Actions. We suggest that the VISN Director ensure that the medical center Director requires contracting officers to: (a) negotiate fair and reasonable prices for nursing home contracts and (b) properly document negotiations in the contract files.

Concur with suggested improvement action:
All new solicitation documents for nursing home care will be sent out without predetermined authorized percentage rates. Chief A&MMS will provide formal training to Purchasing & Contracting personnel on Price Negotiation Memorandums (PNM) before the end of October. Chief Purchasing and Contracts will review all proposed contracts prior to award to ensure proper negotiations occurred and files are appropriately documented.

Target date: Change solicitation documents – Complete
Review all new nursing home contract files - Complete
Train P&C Staff on PNM's – October 2003

Medical Care Collections Fund – Better Identification of Insured Veterans and Stronger Follow Up Would Increase Collections

Suggested Improvement Actions. We suggest that the VISN Director ensure that the medical center Director implements procedures to: (a) obtain and update veteran insurance information at the time of treatment and (b) pursue MCCF receivables more aggressively.

Concur with suggested improvement actions:

a. Obtain and update veteran insurance information at the time of treatment
A script has been provided to the Patient Service Assistants (PSAs) to follow when interviewing veterans. Also, PSAs are printing existing patient demographics at the time veterans present for care and asking the veterans to update any information that is incorrect, specifically asking for insurance verification. The demographics and copies of insurance cards are forwarded to the Business Office. The Business Office verifies insurance then updates the patient information. Business Office will keep these copies and report monthly to the Associate Director the number of updates, new insurance, and number of patients seen using the Business Office Spreadsheet.

Target date: Scripting – Completed
Demographic Information Updates – Begun and ongoing Monthly Reporting in Business Office Spreadsheet – Begin October 2003

b. Pursue MCCF receivables more aggressively
The Business Office has replaced the contract staff following up on aged receivables. A temporary contract has been put in place to collect accounts receivable over 90 days old. A VISN-wide contract to follow-up aged receivables is anticipated and will address this on a VISN-wide basis.

Of note, Muskogee VA Medical Center continues to perform at the "exceptional" level against the VHA performance measure related to decreasing the percentage of dollars for accounts receivables greater than 90 days and it surpassed its annual MCCF collection goal this year for the third year.

Target date: Hire one contract staff to process accounts receivable – Complete
Contract for accounts receivable >90 days follow-up – Complete
Participate in VISN contract for aged receivables – Pending

Quality Management – Better Data Analysis, Action Identification, and Use of Evaluation Criteria Would Strengthen the QM Program

Suggested Improvement Actions. We suggest that the VISN Director ensure that the medical center Director implements procedures to: (a) consistently analyze QM data and identify opportunities to improve the quality of patient care, (b) establish procedures to monitor the implementation of recommendations from QM reviews, and (c) define evaluation criteria for identified corrective actions.

Concur with suggested improvement actions:

a. Consistently analyze QM data
QM will provide mandatory training to service chiefs, committee chairs and supervisors on data analysis and monitor minutes and other QM related documents for compliance on a monthly

basis.

Target date: Training – November 2003
Monitoring and follow up – Begun

b. Establish procedures to monitor for implementation of QM recommendations and
c. define evaluation criteria for corrective actions
Due dates are routinely established for actions arising from standard QM activities such as Root Cause Analyses and Process Action Teams. These are monitored and followed up by QM staff. As an additional measure, QM will provide a quarterly update on completion and efficacy of such actions to the Executive Committee of the Medical Staff and/or Executive Leadership Board as appropriate. Further, a due date column was added to the template for all committee minutes during the CAP review. Medical Center Memorandum 00-1, Publication of Medical Center Administrative Issue Policy, was changed to reflect "Action items will have a due date and will be carried forward in the minutes until complete at which time a completion date will be entered into the minutes." Each QM-related committee will provide information regarding effectiveness of actions taken until the items can be closed as complete.

Of note, VA and other healthcare organizations use the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) accreditation process to assess the quality, safety and environments of care in their facilities. In November 2002, Muskogee VA Medical Center scored 96 and 99 (with no Type 1 recommendations) on its JCAHO comprehensive and home care reviews respectively.

Target date: Monitoring processes - Complete
Committee reports of action effectiveness – Begin November 2003

Information Technology Security – Controls Need to Be Strengthened

Suggested Improvement Actions. We suggest that the VISN Director ensure that the medical center Director requires: (a) VISTA access be promptly terminated for all individuals who do not have a continued need for access, and (b) all system users receive annual computer security awareness training.

Concur with suggested improvement actions:

a. Terminate VISTA access for those without need
Personal Accounting Integrated Data (PAID) separation statistics are reviewed biweekly to assure termination of all unnecessary accounts. ISO reviews ADPAC and VistA reports on a monthly basis to assure inactive accounts are terminated. Modification made to VistA reports to include accounts never activated. Related medical center memoranda have been modified and implemented.

Target date: Review PAID stats - Begun December 2000
ADPAC and VistA report reviews – Begun January 2001 (Modification to VistA report begun September 2003)

b. All system users receive computer security awareness training
95.5% of employees and 53% of "other" staff (contractors, students, work study and volunteers) has received Security Awareness training. ISO continues to follow up and reports to Quadrad.

Community Nursing Home Program – Follow Up on Deficiencies Should Be Improved

Suggested Improvement Action. We suggest that the VISN Director ensure that the medical center

Director implements procedures to follow up on all deficiencies identified during monthly community nursing home inspections.

Concur with suggested improvement action:

The Long Term Care (LTC) Committee was established in early August 2003 and meets monthly for oversight of long term care activities, including contract community nursing homes. This multidisciplinary committee includes the disciplines involved in inspection and review of these homes. Recommendations are given to nursing home management at the time of inspection/review. Recommendations include an expected date of completion and a date for return review for compliance, when that is needed. This information is then sent to the LTC Committee. LTC Committee actions are reported to the Executive Committee of the Medical Staff for review and, if needed, revision. Verification of action taken and completion dates are reported to LTC Committee. The LTC Committee will maintain a log of issues and corrective actions in HBPC and will review it for trends quarterly.

Target date: Complete and Ongoing

Appendix D

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Deputy Chief of Staff (00A1)
Executive Secretariat (001B)
Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
Deputy Under Secretary for Health for Operations and Management (10N)
Medical Inspector (10MI)
VHA Chief Information Officer (19)
Director, National Center for Patient Safety (10X)
Director, Veterans Integrated Service Network (10N16)
Director, Muskogee VA Medical Center (623/00)

Non-VA Distribution

Office of Management and Budget
General Accounting Office
U.S. Senate: James Inhofe and Don Nickles
U.S. House of Representatives: Brad Carson and John Sullivan
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, 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 VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives
- Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives

Appendix D

Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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