Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Sheridan VA Medical Center Sheridan, Wyoming

Report No. 03-02612-27

November 21, 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.

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Executive Summary

Introduction

During the week of September 8–12, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Sheridan VA Medical Center, which is part of Veterans Integrated Service Network (VISN) 19. 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 100 medical center employees.

Results of Review

Service contracts were properly negotiated, and contract prices were reasonable and well justified. Fiscal Section staff aggressively pursued vendor and employee accounts receivable. Our reviews of community nursing home contracts and the environment of care found no significant deficiencies. To improve operations, the medical center needed to:

- Perform inventories of nonexpendable equipment and update inventory records.
- Correct deficiencies in controlled substances inspection procedures and improve security over controlled substances prescriptions.
- Reduce excess medical and engineering supply inventories and strengthen inventory management controls.
- Strengthen controls and correct security deficiencies for automated information system resources.
- Correct medical procedure coding and insurance billing errors and pursue insurance receivables more aggressively.
- Improve oversight for patients living in community residential care facilities.
- Enhance QM by improving data analysis, monitoring implementation of recommendations, and assigning responsibility for follow-up on corrective actions.

VISN 19 and Sheridan 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 14-25 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Mr. David Sumrall, Director, and Ms. Claire McDonald, CAP Review Coordinator, Seattle Audit Operations Division.

(*original signed by*
Michael G. Sullivan,
Deputy Inspector General)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in northern Wyoming, the Sheridan VA Medical Center is a general medical and mental health facility that provides a broad range of inpatient and outpatient health care services. Outpatient and mental health care is also provided at four community-based outpatient clinics in Casper, Riverton, Powell, and Gillette, WY. The medical center serves a population of about 25,150 veterans in Wyoming.

Workload. In Fiscal Year (FY) 2002, the medical center treated 9,386 unique patients, a 13 percent increase from FY 2001. Medical center management attributed the increase in unique patients treated to the steady growth in the number of veterans in the region seeking VA care. The FY 2002 inpatient average daily census (ADC) was 133. For FY 2003 through August 2003, the ADC was 139.5. Outpatient workload totaled 81,531 patient visits in FY 2002 (a 19 percent increase from FY 2001) and 79,435 visits in FY 2003 through August 2003.

Resources. The medical center's FY 2003 medical care budget was $43 million, a 10.3 percent increase over the FY 2002 budget of $39 million. FY 2003 staffing through August 2003 was 381.9 full-time equivalent employees (FTEE), including 20.1 physician and 140.2 nursing FTEE.

Programs. The medical center serves as the VISN 19 psychiatric referral center and has 146 beds. Psychiatry Service has 46 designated inpatient beds for acute and subacute inpatient care. There are 23 medical beds. Extended care services are provided for veterans with a 50-bed nursing home care unit and a 27-bed unit for treatment of serious mental illness, substance abuse, and post traumatic stress disorder.

Affiliations. The medical center has primary affiliations with the University of Wyoming, University of Washington, and Sheridan College to provide clinical training opportunities for medical, nursing, dental hygiene, and dental assistant 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:

- Accounts Receivable
- Automated Information Systems Security
- Community Nursing Home Contracts
- Community Residential Care Program
- Controlled Substances Accountability
- Enrollment and Resource Utilization
- Environment of Care
- Equipment Accountability
- Laboratory Security
- Medical Care Collections Fund
- Pharmacy Security
- Quality Management
- Research Stand Down Compliance
- 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 4–12). 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, 105 of whom responded. We also interviewed 56 patients during the review. The survey and interview results were discussed with the Medical Center Director.

During the review, we also presented 2 fraud and integrity awareness briefings that were attended by 100 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

Vendor and Employee Accounts Receivable Were Aggressively Pursued. Fiscal Section staff had established effective controls for identifying and pursuing delinquent vendor and employee receivables. We reviewed accounts receivable records for the 12-month period September 2002–August 2003 and found that Fiscal Section staff had reviewed the accuracy of billed, collected, and delinquent receivables by reconciling the General Ledger to subsidiary accounting records. We also reviewed collection efforts for all 59 receivables (valued at $51,746) owed as of August 31, 2003, and found no deficiencies. Receivables with recovery potential were aggressively pursued, and receivables that did not have recovery potential were promptly written off as uncollectible.

Service Contracts Were Properly Negotiated, Reasonably Priced, and Well Monitored. As of August 2003, the medical center had 11 nonclinical and 12 clinical service contracts (excluding community nursing home care contracts) valued at about $2.9 million. We reviewed 10 contracts and interviewed responsible contracting officials. The contract files contained proper documentation of the contracting process, including price negotiation memorandums and other required information. Contract prices were reasonable, well justified, and adequately documented. The contracting officers' technical representatives were effectively monitoring contractor performance.

QM Staff Used a Proactive Approach for Improving Patient Monitoring. To improve patient monitoring and better manage provider panels, QM used an automated program to search electronic medical records and identify patients with certain medical conditions that require monitoring, such as diabetes, hypertension, and coronary artery disease. The automated program generated a list of patients who required follow-up care in accordance with accepted clinical practice guidelines. Clinic staff at the medical center used the list to schedule appointments for patients and manage provider panels more efficiently. This proactive approach to monitoring patients with certain conditions has been identified as a best practice in the VISN and has been shared with other medical centers.

Security of the Clinical Laboratory Was Effective. The medical center had a Biosafety Level 2 laboratory. Standard laboratory practices were in place, and biological agents were stored in a secure cabinet. The biological cabinet was located in an area of the laboratory that was not heavily used and away from doors or windows that could easily be opened. Supervisors and employees were knowledgeable about security and personnel access controls in the laboratory.

Opportunities for Improvement

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

Conditions Needing Improvement. Medical center management needed to improve procedures for performing physical inventories and updating equipment inventory lists (EILs) of nonexpendable equipment (items costing more than $300 with an expected useful life of more than 2 years). VA policy requires that EIL inventories be performed at least every 2 years and establishes timeliness standards for completing the inventories based on the number of items on the EILs (10 days from date of notice for EILs with less than 100 equipment items and 20 days for EILs with 100 or more equipment items). At the medical center, Facility Management Service (FMS) staff are responsible for coordinating EIL inventories and updating EIL records. Medical center services are required to perform inventories of assigned equipment and report to FMS when equipment is moved or excessed. We identified five deficiencies with equipment accountability procedures.

EIL Inventories. As of September 2003, the medical center had 46 EILs (2,636 line items; valued at $10.8 million). Although EIL inventories were performed, FMS staff did not document the timeliness of inventories. According to EIL records that we reconstructed for the 2-year period September 2001–August 2003, 18 of the 46 (39 percent) EIL inventories were not completed on schedule, and 4 inventories were not performed at all.

In addition, FMS staff had not performed VA-required quarterly spot checks of the completed EIL inventories to ensure the accuracy of reported information. The FMS employee responsible for coordinating the EIL inventories stated that he was not aware of VA policy that requires these spot checks.

Accuracy of EILs. To verify the accuracy of information on the EILs, we reviewed a judgmental sample of 30 items assigned to 19 EILs (combined value of the 30 items was $1.1 million). Although we were able to locate all 30 items, 6 items (20 percent) had incorrect locations shown on the EILs. This problem occurred because FMS staff did not consistently update EILs when equipment was moved or excessed.

While we were attempting to locate the 30 items, we identified issues with other equipment items not included in our sample. In various storage rooms, we found 96 old, unused computers that were incorrectly included as "in use" on the EILs. The computers had not been turned in for reassignment or disposal as excess as required by VA policy. We also found that 16 police handguns had not been listed on an EIL. Handguns are highly sensitive inventory items and should be included on EILs as accountable inventory.

New Equipment in Storage. According to VA policy, nonexpendable equipment on hand in using services should be only the amount necessary to perform the assigned functions. We found two examples of new equipment that had been stored in boxes for extended periods. Six scanners (valued at $23,756) had been in storage since October 2002, and three printers (valued

at $1,320) had been in storage since June 1998. According to the Chief Information Officer (CIO), the scanners were purchased without the appropriate software and the printers became obsolete soon after purchase because they did not support mandated barcode medical administration.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) services to complete timely EIL inventories and inform FMS staff when equipment is moved or excessed, (b) the FMS staff to perform quarterly inventory spot checks and to update EILs when equipment is moved or excessed, (c) the Chief of FMS to include sensitive items such as handguns on EILs, and (d) service chiefs to plan equipment purchases to ensure that equipment is put into operation when received.

The VISN and Medical Center Directors agreed with the recommendations and reported that plans had been implemented to ensure that EIL inventories are timely, quarterly spot checks are performed, and EILs are updated when equipment is moved or excessed. The target date for full implementation is October 31, 2003. In addition, in September 2003 the Chief of FMS implemented procedures to include sensitive items on the EILs. As of October 2003 monitoring of equipment purchases and utilization had been put into effect. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Controlled Substances – Accountability and Access Deficiencies Should Be Corrected

Conditions Needing Improvement. We reviewed pharmacy security and controlled substances accountability and access to determine if controls were adequate to prevent the loss or diversion of drugs. Although physical security in the pharmacy was effective, we found four deficiencies with controlled substances accountability and access.

Controlled Substances Accountability. Medical center management needed to correct weaknesses in controlled substances inspection procedures. Veterans Health Administration (VHA) policy requires medical facilities to perform monthly inspections of all stocks of controlled substances. The inspection program should be established independently from the pharmacy, and the monthly inspections should have the element of surprise. Inspections must also include all of the procedures outlined in VHA policy. We identified three weaknesses in the medical center's inspection program.

- Monthly inspections did not have the element of surprise. Medical center policy stated that no inspection should be conducted sooner than 20 days from the previous inspection. This resulted in about a 10-day window for performing inspections. In addition, the Controlled Substances Pharmacy Technician routinely provided inspectors a schedule of when she would be available for an inspection during the 10-day window. As a result, the element of surprise was further reduced to a less than 10-day period.

- Inspectors did not count all of the controlled substances in pharmacy stock. During the OIG-observed inspection, the inspectors did not consistently count pills in unsealed medication

bottles. Instead, they relied on counts that pharmacy staff had previously recorded on the bottle labels.

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

Access to Controlled Substances Prescriptions. VHA policy requires that controlled substances prescriptions waiting for outpatient pickup must be stored in a locked area, such as a cabinet. We found that during pharmacy business hours, these prescriptions were not locked in a cabinet. Instead, they were stored on shelves in the open pharmacy area with other prescriptions and where all pharmacy staff routinely had access.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) monthly controlled substances inspections are conducted with the element of surprise, (b) controlled substances inspectors follow all VHA policies and procedures for conducting inspections, and (c) controlled substances prescriptions waiting for outpatient pickup are properly secured.

The VISN and Medical Center Directors agreed with the recommendations and reported that plans had been implemented to ensure that controlled substances inspections are performed in accordance with all VHA requirements. The target date for full implementation is December 1, 2003. By November 10, 2003, all controlled substances prescriptions waiting for outpatient pickup will be secured in a locked cabinet, which has been ordered. 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 and engineering supplies and make better use of automated controls to more effectively manage supply inventories. In FY 2002, the medical center spent approximately $420,400 on medical and engineering supplies. The VHA Inventory Management Handbook establishes a 30-day supply 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. Supply, Processing, and Distribution (SPD) Section staff used GIP to manage the medical supply inventory. However, they were not fully using GIP features to meet the inventory goal of 30 days or less. As of August 2003, the SPD medical supply inventory consisted of 570 items with a stated value of $54,416.

To test 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

items reviewed, the GIP-reported value was $23,637. The actual value of this stock was $8,915, which was only 37.7 percent of the GIP-reported value. Applying the 37.7 percent figure to the $54,416 value for the entire medical supply stock shown in GIP would yield an estimated total value of $20,515. Second, stock on hand exceeded 30 days. Seventeen of the 20 sampled items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 62 days to 6 years of supply. The estimated value of stock exceeding 30 days for the 17 items was $4,190, or 47 percent of the estimated total value of the 20 items.

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-day 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 47 percent of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock was about $9,642 (47 percent times $20,515 estimated total value of stock).

Engineering Supplies. FMS did not use GIP or any other formal method to manage the 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 supply items (valued at $3,209). Because FMS did not use GIP, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for 8 of the 10 items, with inventory levels ranging from 42 to 400 days of supply (excess valued at $2,171). Excess engineering supply inventory occurred because FMS did not use GIP or other inventory controls. 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.

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

The VISN and Medical Center Directors agreed with the recommendations and reported that the medical center had implemented procedures to reduce excess medical supply inventory and improve the accuracy of GIP. These procedures included offering excess items to other federal facilities, removing non-usable items from inventory, discontinuing low-use items, performing quarterly reviews of usage and inventory levels, and issuing some items to secondary supply sites as appropriate. The target date for full implementation is November 1, 2003. The medical center has also taken actions to monitor engineering supply usage rates and fully implement GIP for controlling engineering supply inventory. The target date for full implementation of these actions is September 30, 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Automated Information Systems Security – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed medical center automated information systems (AIS) security to determine if controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that Information Resource Management (IRM) staff had implemented virus detection procedures and established effective controls for assigning passwords. However, we identified five AIS security issues that required corrective action.

Contingency Plan. The medical center's AIS contingency plan was only in draft format. The draft plan did not include a designated alternate processing facility that could provide backup to AIS services in the event that the primary facilities were severely damaged or could not be accessed. Once established, the contingency plan will provide alternate methods for delivering critical interim support for the facility and provide for an expedient recovery process in the event of a disruption of services. The Information Security Officer (ISO) and CIO estimated that the plan would be completed by the end of March 2004.

Backup Data Storage. AIS staff stored computer system backup files in a building adjacent to the computer room building. VHA policy requires that essential data be backed up and stored in a location physically separate from the AIS and that the actual location of the backup must be determined by analysis of local risk. While the VHA policy does not provide a specific distance requirement for the backup storage location, the CIO agreed that the storage location adjacent to the computer room building did not satisfy local risk considerations.

ISO Appointment. VHA policy allows ISOs at smaller facilities to have ancillary non-ISO duties. However, the primary duties must be those of an ISO. At this medical center, the employee assigned the ISO duties was also assigned the duties of the Automated Data Processing Application Coordinator. This employee stated that the duties for each position required a full-time effort and that the ISO duties were not his primary duties. Medical center management needed to evaluate the ISO's position and ensure that his duties are properly structured so that he can effectively meet all ISO responsibilities.

Physical Security. The computer room did not have adequate entry controls to restrict and monitor access. VHA policy requires that all access to the computer room be logged and reviewed. The ISO is responsible for reviewing this log to determine if the individuals logging in still have an official need to access the computer room. Access to the medical center's computer room was only logged intermittently. However, the CIO had submitted a work order for installation of an electronic access system that will automatically log access by user code.

Internet Monitoring. Since July 2001, the ISO had not routinely monitored employee use of the Internet. VHA policy requires Internet monitoring to detect and report unauthorized or inappropriate use.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the AIS contingency plan is finalized, (b) backup

files are stored at a more appropriate off-site location, (c) the ISO position is evaluated to ensure that all ISO responsibilities are met, (d) computer room access is consistently monitored, and (e) employee Internet usage is routinely monitored.

The VISN and Medical Center Directors agreed with the recommendations and reported that by December 31, 2003, the ISO and CIO will update the facility AIS contingency plan and identify an off-site storage location for backup files. As of October 2003, the Medical Center Director had completed a review of the ISO position and determined that the needs of the position could be met with the currently assigned resources. In addition, data recording locks were installed on the computer room in October 2003 to monitor access more consistently. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medical Care Collections Fund – Coding, Billing, and Collection Procedures Should Be Improved

Conditions Needing Improvement. Medical center staff needed to ensure that only bills with correct diagnostic and procedure codes were sent to insurers for collection and accounts receivable from insurers were more aggressively pursued. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain veterans who have insurance. Typically, insurance companies will not pay 100 percent of the amount billed. The amount a facility collects (its collection rate) depends on several factors, such as the type of insurance a veteran has and the scope of services the veteran receives. As of August 1, 2003, the medical center's FY 2003 collection rate was 37.5 percent.

Coding and Billing Errors. MCCF staff needed to ensure that only bills with correct diagnostic and procedure codes were sent to insurers for collection. To verify the accuracy of coding, we reviewed patient medical records corresponding to 20 unpaid bills valued at $198,720 (5 inpatient valued at $172,160 and 15 outpatient valued at $26,560). We identified coding errors on 6 of the 20 bills (30 percent). Three bills were assigned codes with lower reimbursement values than supported by the medical record documentation. As a result, these bills were understated by $49,594. The other three bills were assigned codes with higher reimbursement values, which resulted in the bills being overstated by $838. The net understated value of the six incorrect bills was $48,756 ($49,594 - $838). If the medical center corrects the six bills and reissues them to insurers, it can expect to collect an additional $18,284 ($48,756 net understated value times 37.5 percent collection rate).

Pursuit of MCCF Receivables. As of August 1, 2003, the medical center had 14,586 MCCF accounts receivable with a total value of $3,815,331. Of these, 4,007 with a value of $1,219,946 (32 percent of the total value) were more than 90 days old. Based on its FY 2003 collection rate, the medical center can expect to collect about $457,480 from these receivables ($1,219,946 times 37.5 percent). To evaluate the collection potential for these receivables, we reviewed 50 bills (valued at $160,514). Based on our review and discussions with the MCCF Supervisor, we determined that more aggressive collection actions were needed. To aggressively pursue accounts receivable, multiple collection letters should be sent and follow-up telephone calls should be made. After sending bills, MCCF staff did not routinely make follow-up calls to

insurers to determine why payments had not been made. Based on discussions with the MCCF Supervisor, we estimate that if MCCF staff pursued receivables more aggressively they could increase the collections by about 10 percent, which would provide the medical center with additional revenue of about $45,748 ($457,480 expected collections times 10 percent).

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director implements procedures to: (a) rebill the insurance companies for the six incorrect bills identified by our review, (b) review other outstanding bills for coding accuracy to determine if there is further collection potential and submit amended bills as appropriate, and (c) pursue MCCF receivables more aggressively.

The VISN and Medical Center Directors agreed with the suggestions and reported that as of October 2003 MCCF staff had rebilled the incorrect bills identified by our review. In addition, plans were implemented to review the coding accuracy of bills generated for special medical procedures during the period April–September 2003. Erroneous bills will be rebilled as appropriate. The target date for completing the audit and reporting the results to medical center management is January 15, 2004. As of October 2003, a process to pursue receivables more aggressively had been implemented. The target date of full implementation is January 15, 2004. The improvement plans are acceptable, and we consider the issues resolved.

Community Residential Care Program – Oversight Procedures Needed Improvement

Conditions Needing Improvement. Medical center management needed to improve oversight for patients living in community residential care (CRC) facilities. As part of the medical center's CRC program, the medical center arranged housing for three patients at a residential care facility (RCF). To evaluate compliance with VHA policies, we interviewed program managers and reviewed local policies and procedures, patient medical records, and RCF inspection files. We identified deficiencies in six areas of the CRC program.

Team Inspections. VHA policy requires that an interdisciplinary team consisting of a social worker, nurse, dietitian, and fire safety specialist inspects RCFs at least every 2 years. Although the social worker and the fire safety specialist inspected the RCFs annually, neither a nurse nor a dietitian participated in these inspections. These interdisciplinary team inspections are critical to ensure that RCFs comply with all VHA clinical and safety requirements.

Physical Examinations. Medical center clinicians are required to ensure that RCF patients receive annual physical examinations. We reviewed the medical records of all three patients in the CRC program and found that none had received their physical examination in the past year.

Provider Training. VHA policy requires that VA staff provide annual training to RCF providers and employees to ensure they have the skills required to meet the needs of CRC patients. According to the CRC Program Coordinator, this training had not been provided as required.

Oversight of Fiduciaries. VHA policy requires that CRC program staff meet annually with Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) staff to discuss joint responsibilities and concerns involving incompetent veterans who have been assigned fiduciaries. These meetings provide opportunities to share information concerning the needs of veterans residing in RCFs and the observed conditions of the RCFs. The CRC Program Coordinator was unaware of this requirement and told us that he would arrange to meet with VBA F&FE staff as required.

Quality of Care Monitors. VHA policy requires that facilities integrate the CRC program into the facility-wide QM program. CRC program managers are required to establish quality of care monitors to identify problems in the care provided to patients and opportunities for improvement. Medical center managers had not established quality of care monitors for the CRC program.

Policy Revision. Medical center CRC program policies did not comply with VHA policies. For example, the policy on RCF inspections required that full team inspections be conducted only in cases where the Community Advisory Board felt it was necessary instead of every 2 years as required by VHA policy. The CRC Program Coordinator told us that he would update local policies to reflect the new VHA Community Residential Care Program Handbook.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires: (a) the full CRC team to conduct RCF inspections at least every 2 years, (b) clinicians to perform and document annual physical examinations of RCF patients, (c) medical center staff to provide annual training to RCF providers and employees, (d) the CRC Program Coordinator to arrange an annual meeting with VBA F&FE staff to discuss issues involving incompetent veterans with fiduciaries, (e) the CRC Program Coordinator to establish quality of care monitors, and (f) CRC program managers to revise local CRC policies to ensure compliance with VHA policies.

The VISN and Medical Center Directors agreed with the suggestions and reported that as of October 2003, the medical center had developed plans to ensure that a full CRC team conducts RCF inspections every 2 years, physical examinations are performed and documented for the three current RCF residents, and QM monitors are established for the CRC program. On October 10, 2003, the CRC Program Coordinator met with VBA F&FE staff. By December 31, 2003, the CRC Program Coordinator will conduct training for RCF providers and employees and complete a draft CRC policy. The improvement plans are acceptable, and we consider the issues resolved.

Quality Management – Better Data Analysis, Evaluation Criteria, and Follow-up of Actions 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. However, although data was collected in all areas required by accreditation standards, it

was not consistently analyzed. In addition, senior managers and program coordinators did not document how the effectiveness of the actions would be evaluated or assign responsibility for follow-up on corrective actions. We discussed the results of our review with medical center managers and they agreed with our findings.

Data Analysis. Data on adverse drug events were collected and reported to the Pharmacy and Therapeutics Committee. However, there was no documented evidence that further analysis or discussion took place. No conclusions or recommendations were made to address problem areas, and no action items were identified.

Evaluation Criteria. Service chiefs and program coordinators had identified criteria to use in determining whether corrective actions were effective in root cause analyses (RCAs). However, they needed to identify criteria to evaluate the effectiveness of actions for all QM monitoring functions, as required by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. Evaluation criteria were not consistently defined for corrective actions identified in areas such as patient falls and outcomes from resuscitation.

Follow-up on Corrective Actions. We did not find evidence that service chiefs and program coordinators consistently implemented and evaluated recommended QM actions in several review areas, including RCAs, patient falls, and outcomes from resuscitation, as required by JCAHO standards. To provide reasonable assurances that responsible employees provide appropriate follow-up, medical center managers need a strong system for ensuring that implementation, evaluation, and follow-up of all recommendations are completed.

Suggested Improvement Actions. We suggested 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 and effectiveness of recommendations from QM reviews, and (c) assign responsibility for follow-up on corrective actions.

The VISN and Medical Center Directors agreed with the suggestions and reported that the medical center had developed procedures to ensure that QM data is analyzed consistently, the implementation and effectiveness of recommendations from QM reviews are better monitored, and responsibility for follow-up on corrective actions is assigned. For example, QM staff will collect all facility-wide patient care quality data for trending, analysis, and reporting. The improvement plans are acceptable, and we consider the issues resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
3 a	Better use of funds by reducing excess medical supply inventory.	$9,642
N/A	Better use of funds through collection of amended MCCF bills and more aggressive collection.	$64,032
	Total	$73,674

Appendix B

VISN 19 Director Comments

Department of Veterans Affairs

Memorandum

Date: October 24, 2003

From: Network Director, VISN 19 (10N19)

Subj: Draft Report – CAP Review of Sheridan VAMC
Inspection Number 2003-02612-R8-0147

To: Assistant Inspector General for Healthcare Inspections (52)

Thru: Ms. Peggy Seleski, Director, Management Review Service (10B5)

Attached is the VISN 19 response on the recommendations for improvement contained in the draft Combined Assessment Program review at Sheridan VAMC. If there are any questions or concerns, please contact Craig Calvert, VISN 19, at 303-756-9279.

Original signed by Ken Maffet, M.D. for:
Lawrence A. Biro, Ed.D.

Attachment

Appendix C

Sheridan VA Medical Center
Director Comments

Department of Veterans Affairs

Memorandum

Date: October 31, 2003

From: Medical Center Director, VAMC Sheridan, WY (666)

Subj: Response/Action Plan to Office of Inspector General CAP

To: Assistant Inspector General for Auditing

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program draft report of the Sheridan VAMC. Comments and the implementation plan are included with the transmittal of this memorandum.

2. I am pleased with the outcome of the review and the affirmation that the Sheridan VAMC provides high quality healthcare to our Nation's veterans. Please express my appreciation to the auditors and support staff who conducted the review during the week of September 8-12, 2003. The Medical Center staff appreciated their professionalism and efforts to assist in improving hospital operations and controls.

3. Should you have any questions regarding the comments or implementation plan, please do not hesitate to contact me.

Original signed by:
Maureen Humphrys
Medical Center Director

Appendix C

SHERIDAN VA MEDICAL CENTER
Comments and Implementation Plan

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

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires: (a) services to complete timely EIL inventories and inform FMS staff when equipment is moved or excessed, (b) the FMS staff to perform quarterly inventory spot checks and to update EILs when equipment is moved or excessed, (c) the Chief of FMS to include sensitive items such as handguns on EILs, and (d) service chiefs to plan equipment purchases to ensure that equipment is put into operation when received.

a. Services to complete timely EIL inventories and inform FMS staff when equipment is moved or excessed:

Concur with recommended improvement action:

Chief, FMS, will obtain documentation of service Equipment Inventory List (EIL) and the timeliness of the inventories. If services are not timely, the Associate Medical Center Director/COS will be notified for further action. Procedures have been established for moving or excessing equipment. These procedures will be communicated by memorandum to all services by October 31, 2003. FMS Supply Manager/Designee will monitor compliance through periodic spot checks of the inventories.

Target Date: October 31, 2003

b. FMS staff to perform quarterly inventory spot checks and to update EILs when equipment is moved or excessed:

Concur with recommended improvement action:

A facility-wide quarterly schedule for the all Programs/Services has been developed. A quarterly inventory spot check is scheduled for October 20, 2003 for Primary Care followed by FMS on November 10, 2003. All other programs/services will follow. FMS Supply Manager/Designee will enforce procedures for correcting and upgrading inaccurate and incomplete EILs with service and monitor compliance spot checks. Procedures for moving or excessing equipment will be communicated by memorandum to all services by October 31, 2003.

Target Date: October 31, 2003

c. The Chief of FMS to include sensitive items such as handguns on EILs:

Concur with recommended improvement action:

At the time of the CAP review, handguns were on the EIL but costs associated with the

handguns were not included. FMS has entered this information and corrected the record. Chief, FMS will ensure that information is complete on sensitive items entered on the EIL and monitor compliance through normal EIL inventory cycles and by having staff perform quarterly inventory spot checks.

Completed: September 18, 2003

d. Service Chiefs to plan equipment purchases to ensure equipment is put into operation when received:

Concur with recommended improvement action:

New IRM equipment in storage (as noted in our CAP Survey) has been acted upon. The six scanners found will be in service on station by December 31, 2003. The three printers have been turned in as surplus to other VAs.

Target Date: December 31, 2003

Ensuring equipment is put into operation is the responsibility of the Service Chief receiving the equipment. The Service Chief makes equipment requests based on immediate or anticipated needs and puts equipment into service when received. If needs change, the service will report the exception to the Chief, FMS, and initiate a turn-in for proper utilization. Compliance will be monitored by Chief, FMS, through a quarterly spot-check of EILs.

Target Date: October 20, 2003

Controlled Substances – Accountability and Access Deficiencies Should Be Corrected

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) monthly controlled substances inspections are conducted with the element of surprise, (b) controlled substances inspectors follow all VHA policies and procedures for conducting inspections, and (c) controlled substances prescriptions waiting for outpatient pickup are properly secured.

a. Monthly controlled substances inspections are conducted with the element of surprise:

Concur with recommended improvement actions:

Monthly controlled substance inspections will be conducted at random dates/times in accordance with the requirements of VHA Handbook 1108.2, dated August 29, 2003. The Controlled Substance Coordinator (Associate Medical Center Director) will meet with all Inspecting Officials, Supervisory Pharmacist, and Nurse Executive to communicate this requirement and the expectation for compliance. The Controlled Substance Coordinator will track dates and times of each review and provide a biannual report to Leadership.

Target Date: December 1, 2003

b. Controlled substances inspectors follow all VHA policies and procedures for

conducting inspections:

Concur with recommended improvement actions:

The Medical Center Memorandum will be updated by the ACOS, Patient Care Support Program, to reflect all requirements for inspection of controlled substances as set forth in VHA Handbook 1108.2, dated August 29, 2003. The Controlled Substance Coordinator will assure all Inspecting Officials receive appropriate training and understand the requirements.

Target Date: December 1, 2003

c. Controlled substances prescriptions waiting for outpatient pickup are properly secured:

Concur with recommended improvement actions:

Controlled substances prescriptions waiting for outpatient pickup will be secured in a locked cabinet; the cabinet has been ordered. The Supervisory Pharmacist will oversee the process and monitor day-to-day compliance. In addition, the Controlled Substance Inspection Team will monitor compliance of the outpatient pick-up area at the time of their monthly inspection.

Target Date: November 10, 2003

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) SPD to reduce excess medical supply inventory and improve the accuracy of GIP data and (b) FMS to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP.

General Facility Comment: The SPD and logistics functions of the Medical Center are undergoing a complete reorganization that will consolidate inventory management functions and provide better leadership support for the entire program. The reorganization has been approved and the medical center is recruiting for a supervisory Supply Manager to provide more concentrated oversight of all medical center supply and equipment management functions. It is anticipated that the reorganization will be complete and fully staffed before February 1, 2004.

Supply, Processing, and Distribution (SPD) Section:

a. SPD to reduce excess medical supply inventory and improve the accuracy of GIP data:

Concur with recommended improvement actions:

To reduce excess medical inventory and to improve the accuracy of GIP data, the following

measures have been taken:

- As of September 22, 2003, twenty-six SPD inventory items that have not been used within one year have been offered as excess to other federal facilities to reduce inventory levels.
- Inventory deemed non-usable due to condition has been removed from inventory.
- Items on "Kill When Zero" (KWZ) status for non-usage have been discontinued.
- Chief, FMS/FMS Supply Manager will review Use and Inventory Levels on all inventory items quarterly and make adjustments as necessary. The first review is scheduled for completion prior to October 31, 2003.
- Chief, FMS/FMS Supply Manager will utilize reorder points of zero as necessary and appropriate. Items appropriate for this will be identified during quarterly reviews.
- Users will be required to discontinue low-use items as possible. These items will be identified during quarterly reviews.
- Chief, FMS/FMS Supply Manager will issue low-volume usage items to secondary supply sites/units as appropriate.

Target Date: November 1, 2003

b. FMS to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP:

Concur with recommended improvement actions:

In an effort to improve monitoring of supply usage rates, several actions are being taken

- FMS inventory is on the GIP as of October 1, 2003,
- Chief, FMS, will monitor the Days of Stock in Hand Report monthly and make quarterly reviews with staff to make adjustments to stock levels,
- Chief, FMS will conduct quarterly audits to monitor the accuracy and effectiveness of the FMS inventory (the first inventory to be complete before October 31, 2003), and
- Inventory management staff will be provided additional (GIP) training.

Target Date: January 1, 2004

An annual physical inventory is scheduled for November 8, 2003, per VHA Handbook 1761.2 (VHA Inventory Management). Inventory reconciliation and data entry will be completed the same day.

Target Date: November 8, 2003

FMS Engineering Section:

Concur with recommended improvement actions:

The Engineering Section implemented GIP on October 1, 2003. Legacy inventories are being addressed as individual shops are consolidated and as physical moves take place. It will take 12 months from the implementation of GIP to completely address excess engineering inventories and will include the plumbing shop, paint shop, carpenter shop, boiler plant, grounds maintenance shop, and biomedical engineering shop. Chief, FMS, will oversee and be responsible for completion of the GIP.

Target Date: September 30, 2004

Automated Information Systems Security – Controls Should Be Strengthened

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director ensures that: (a) the AIS contingency plan is finalized, (b) backup files are stored at a more appropriate off-site location, (c) the ISO position is evaluated to ensure that all ISO responsibilities are met, (d) computer room access is consistently monitored, and (e) employee Internet usage is routinely monitored.

a. The AIS contingency plan is finalized:

Concur with recommended improvement actions:

The ISO and CIO are updating the facility contingency plan and it will be completed by December 31, 2003. One of the main elements is the designation of an alternate processing site in the event of an emergency. The VISN CIO has been involved in the selection of an alternate processing site and has recommended using Denver. This plan is being incorporated into the facility contingency plan.

Target Date: December 31, 2003.

b. Backup files are stored at a more appropriate off-site location:

Concur with recommended improvement actions:

The ISO and CIO are exploring alternate storage sites for the backup tapes. We are considering an arrangement with the local community hospital to provide a storage site.

Target Date: December 31, 2003.

c. The ISO position is evaluated to ensure that all ISO responsibilities are met:

Concur with recommended improvement actions:

Management has completed a review of the Position Description with the ISO. Although the ISO position is not a fulltime position in Sheridan, it is the primary duty of the employee assigned. Expectations have been reinforced with the incumbent. Management feels that the needs of the position can be met at this time with the assigned resources.

Completed: October 1, 2003.

d. Computer room access is consistently monitored:

Concur with recommended improvement actions:

Data recording locks similar to those used to secure the pharmacy and the telephone switch

room will be installed on the computer room doors. This will allow monitoring room access.

Completed: October 17, 2003.

e. Employee Internet usage is routinely monitored:

Concur with recommended improvement actions:

The Elron Internet Manager Software was formerly employed to monitor Internet use. Network changes at the gateway level made this tool unusable. The ISO is implementing a random manual monthly review of system history files. Immediate reports will be provided as warranted. A summary report will be sent to the Director quarterly.

First Report Due: October 31, 2003.

Medical Care Collections Fund – Coding, Billing, And Collections Procedures Should Be Improved

Suggested Improvement Actions: We suggest that the VISN Director ensure that the Medical Center Director implements procedures to: (a) rebill the insurance companies for the six incorrect bills identified by our review, (b) review other outstanding bills for coding accuracy to determine if there is further collection potential and submit amended bills as appropriate, and (c) pursue MCCF receivables more aggressively.

a. Rebill the insurance companies for the six incorrect bills identified by our review:

Concur with suggested improvement actions:

The following is a list of the six incorrect bills and the action taken.
K3027Y8 – rebilled as appropriately documented w/o contrast on K40022R
Dated 10-9-03, mailed with cover letter 10-14-03

K302FGV – rebilled as appropriately documented on K40022H
Dated 10-9-03, mailed with cover letter 10-14-03

K302HEU – rebilled as appropriately documented on K40025A and K40025B
Dated 10-10-03, mailed with cover letter 10-14-03

K3024GQ – rebilled with appropriate DX on K400263
Dated 10-10-03, mailed with cover letter 10-14-03

K3020LD – rebilled with additional codes on K40025P
Dated 10-10-03, mailed with cover letter 10-14-03

K3027HL – further review indicated the policy had expired on 7-30-02, which was prior to the date of service.

Completed: October 14, 2003.

b. Review other outstanding bills for coding accuracy to determine if there is further collection potential and submit amended bills as appropriate:

Concur with suggested improvement actions:

The MCCR Coordinator has implemented a process requiring that all bills generated for special procedures from April through September 2003 will be audited for accuracy and rebilled as appropriate. This audit will take place October-December 2003. A coder, other than the one who originally prepared the bill, will perform the audit. A report will be issued to Leadership following completion of the audit with a final report.

Target Date: January 15, 2004.

c. Pursue MCCF receivables more aggressively:

Concur with suggested improvement actions:

The MCCR Coordinator has implemented a process requiring the Account Receivable Personnel to make telephone calls from the Over Thirty-Day Delinquent List and document the results in the "Comment" field. This procedure was implemented October 6, 2003. The MCCR Coordinator will monitor performance with quarterly reports to Leadership.

Target Date: January 15, 2004.

Community Residential Care Program – Oversight Procedures Needed Improvement

Suggested Improvement Actions. We suggest that the VISN Director ensure that the Medical Center Director requires: (a) the full CRC team to conduct RCF inspections at least every 2 years; (b) clinicians to perform and document annual physical examinations of RCF patients; (c) medical center staff to provide annual training to RCF providers and employees; (d) the CRC Program Coordinator to arrange an annual meeting with VBA F&FE supervisors to discuss issues involving incompetent veterans with fiduciaries; (e) the CRC Program Coordinator to establish quality of care monitors; and (f) CRC program managers to revise local CRC policies to ensure compliance with VHA policies.

a. Full CRC team to conduct RCF inspections at least every 2 years:

Concur with suggested improvement actions:

Inspection of RCF homes will be accomplished every 24 months (sooner if warranted) by a full VA inspection team to include the Fire & Safety Officer, Nurse, Dietitian, and Social Worker. The CRC Program Coordinator will organize the team and schedule inspections.

Target Date: October 31, 2003. Inspection scheduled for October 28, 2003

b. Clinicians to perform and document annual physical examinations of RCF Program patients:

Concur with suggested improvement actions:

Each veteran in the CRC program will have an annual full medical history and physical examination completed and documented in his/her VA medical record. A full medical history and physical examination has been scheduled and will be completed for each of the three current RCF residents by October 31, 2003. The CRC will monitor H&P completion and continued compliance.

H&P's scheduled for October 2003.

c. Medical center staff to provide annual training to RCF providers and employees:

Concur with suggested improvement actions:

The CRC Program Coordinator will set a schedule for annual training conducted by VA staff to RCF providers and their employees. The CRC Coordinator will document training offered to RCF providers and maintain attendance records.

Target Date: Training will be completed by December 31, 2003

d. The CRC Program Coordinator to arrange an annual meeting with VBA F&FE supervisors to discuss issues involving incompetent veterans and fiduciaries:

Concur with suggested improvement actions:

The CRC Program Coordinator will arrange an annual meeting with VBA F&FE Supervisors to discuss issues involving incompetent veterans in the CRC program who receive VA funds.

Completed. The first meeting was held October 10, 2003.

e. The CRC Program Coordinator will establish quality of care monitors:

Concur with suggested improvement actions:

QM monitors for CRC program will be developed to track falls, missed VA clinic appointments, and hospitalizations. Results of ongoing QM monitors will be reported Quality Management and then reported to Leadership.

Target Date: October 31, 2003

f. CRC program managers to revise local CRC policies to ensure compliance with VHA policies:

Concur with suggested improvement actions:

The CRC Coordinator will revise local the CRC policy to ensure compliance with VHA policies.

Revision is currently in process. Draft policy due December 31, 2003.

Quality Management – Better Data Analysis, Evaluation Criteria and Follow-up of Actions 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 and effectiveness of recommendations from QM reviews, and (c) assign responsibility for follow-up on corrective actions.

a. Consistently analyze QM data and identify opportunities to improve the quality of patient care:

Concur with suggested improvement actions:

All facility-wide patient care quality data will be reported to Quality Management for trending, aggregation, analysis, and appropriate reporting. QM has managed VISN-required performance measures but various JCAHO required data and local performance improvement project data has been collected and reported in committees. Trending and analysis has not been consistently performed on data collected outside of QM. To improve the process and provide consistency, QM will be the repository of all performance measure data for VISN, facility, and surveying bodies.

The Root Cause Analysis Process in Sheridan is a process fully embraced by Leadership. When an adverse event occurs that requires review, the Director and Chief of Staff confer and charter teams. The closeouts are conducted with the entire chartered team, the Medical Center Director, Chief of Staff, Patient Safety Officer, appropriate Program ACOS, and QM. The Director personally reviews and provides comments to the recommendations. The Director then assigns responsibility and deadlines to all recommendations. Although our RCA process is exceptional, the tracking of outcome measures related to the recommendations has not been well documented. QM and Leadership appreciated the OIG inspector/auditor's recommendations for process improvement of the RCA tracking tool. QM will manage the documentation, trending and analysis of recommendation outcomes and will periodically report to Leadership on the effectiveness of improvements. QM will follow up on recommendations from Focused Reviews in the same manner.

Pharmacy and Therapeutics will redesign their minutes to include a comprehensive section for Adverse Drug Reactions. Documentation will include reporting and follow-up actions on a monthly basis. QM will complete aggregation and trending.

The responsibility for trending and aggregation of resuscitation data has been shifted from a committee to Quality Management. Required actions that have resulted from the analysis of the data will be communicated to the Clinical Executive Board and the Emergency Care Committee.

Target Date: December 31, 2003

b. Establish procedures to monitor the implementation and effectiveness of

recommendations from QM reviews and

c. Assign responsibility for follow-up on corrective actions:

Concur with suggested improvement actions (b & c):

QM will develop a data grid that includes all VISN, facility, and accreditation requirements. Required PI data will be collected, analyzed, trended and reported by QM. Leadership will receive quarterly reports (at a minimum). The data will also be disseminated at the QM Meeting. Supervisors will share the information with frontline staff.

An additional column was added to the RCA tracking tool, which will indicate the status/outcome of all recommendations. The Patient Safety Officer maintains the database. The RCA Teams are responsible for the development of the recommendations and will have the responsibility for evaluating the effectiveness of recommendations. They can suggest if additional intervention is required to meet their intentions (i.e. training, policy development) or they can recommend the item be closed. QM will be responsible for tracking corrective actions for RCAs and Focused Reviews

Resuscitation data will be trended by QM with reporting to the Clinical Executive Board and the Emergency Care Committee. The Chairs of the committees will assign required follow-up of system issues.

The Quality Manager will review the Pharmacy and Therapeutics Committee meeting minutes to assure that ADR reporting, documentation, and follow-up meets the intent of JCAHO standards and VA policies.

Target Date: December 31, 2003

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	David Sumrall (206) 220-6654
Acknowledgements	Gary Abe Daisy Arugay Danny Bauwens Kevin Day Claire McDonald Barbara Moss Rayda Nadal Angie Stow

Appendix E

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Appendix E

Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
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