Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Southern Nevada Healthcare System Las Vegas, Nevada

Report No. 04-00489-167

July 15, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of February 23-27, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Southern Nevada Healthcare System (the healthcare system), which is part of Veterans Integrated Service Network (VISN) 22. The purpose of the review was to evaluate selected 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 431 employees.

Results of Review

This CAP review covered 14 areas. As indicated below, no concerns were identified in seven areas:

- Agent Cashier
- Environment of Care
- Government Purchase Card Program
- Accounts Receivable
- Information Technology Security
- Part-Time Physician Time and Attendance
- Primary Care Clinics

To improve operations, we recommended the following:

- Strengthen pharmacy controls, safeguards, and security.
- Conduct equipment inventory counts and update inventory lists.
- Fully implement the Generic Inventory Package (GIP) to manage medical supplies.

Suggested improvements included:

- Strengthen coding, billing, collection procedures, and clinical documentation.
- Strengthen two QM program areas and overall QM review processes, also QM activities that are shared with the Mike O'Callahan Federal Hospital (MOFH).
- Document that patients scheduled to receive moderate sedation have medical evaluations within 30 days prior to procedures and again immediately prior to receiving sedation.
- Strengthen contract award administration and documentation.

This report was prepared under the direction of Ms. Julie Watrous, Director, and Dr. Wilma Wong, CAP Coordinator, Los Angeles Regional Office of Healthcare Inspections.

VISN and Healthcare System Director Comments

The VISN 22 Director and the Acting Healthcare System Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendices A and B, pages 13-24 for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

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

Introduction

Healthcare System Profile

Organization. The healthcare system provides inpatient and outpatient health care services in Las Vegas, Nevada, and provides outpatient care at community-based outpatient clinics located in Pahrump and Henderson, Nevada. The healthcare system is part of VISN 22 and serves a veteran population of about 49,000 in a primary service area that includes Clark, Lincoln, and Nye counties in Nevada.

Programs. The healthcare system provides medical, surgical, and mental health care services. The healthcare system has 52 hospital beds at the MOFH as part of a sharing agreement with the Department of Defense at Nellis Air Force Base in Las Vegas.

Affiliations and Research. The healthcare system is affiliated with the University of Nevada School of Medicine and supports 27 medical resident positions. The healthcare system is also affiliated with several colleges to provide clinical training opportunities for nursing, optometry, and allied health students. In Fiscal Year (FY) 2003, the healthcare system's research program had 12 projects and a budget of $105,000. Important areas of research include endocrinology, oncology, and Hepatitis C viral infection.

Resources. In FY 2002, the healthcare system's medical care expenditures totaled $105.2 million. The FY 2003 medical care budget was $150.5 million, a 43 percent increase over FY 2002 expenditures. This increase included funds for relocation of patient care services due to structural defects. FY 2003 staffing was 708 full-time equivalent employees (FTEE), including 72 physician and 132 nursing FTEE.

Workload. In FY 2003, the healthcare system treated 37,416 unique patients, a 4.5 percent increase over FY 2002. The inpatient care workload totaled 2,202 discharges, and the average daily census was 39. The outpatient workload was 311,665 visits.

Objectives and Scope of the 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 health care facility operations, focusing on patient care, QM, and financial and administrative controls.

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered healthcare system operations for FY 2003 and FY 2004 through January 2004 and was done 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 activities:

Accounts Receivable	Moderate Sedation
Agent Cashier	Part-Time Physician Time and Attendance
Environment of Care	Pharmacy Service Accountability
Equipment Accountability	Primary Care Clinics
Government Purchase Card Program	Quality Management Program
Information Technology (IT) Security	Service Contracts
Medical Care Collections Fund (MCCF)	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 made 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 healthcare system managers 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 patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees and 116 responded. We also interviewed 37 patients during the review. We discussed the interview and survey results with healthcare system managers.

During the review, we also presented 9 fraud and integrity awareness briefings for 431 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strengths

Relocation of Ambulatory Care Center Was Accomplished Successfully. During FY 2002, after the discovery of structural defects in the 180,000 square foot Ambulatory Care Center (ACC) building in Las Vegas, healthcare system management developed plans for relocation to alternative sites. Execution of the relocation plans maintained clinical programs and services with minimal disruption to veteran patients. The relocation efforts directly involved over 700 employees and over 49,000 enrolled veteran patients. All patient care programs were successfully relocated from the ACC to 11 separate locations in Las Vegas between January and June 2003. The relocation plan and its execution were recognized as exceptional at the VA national level.

Information Technology Security Was Generally Effective. The healthcare system had adequate IT security to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for computer rooms and equipment was adequate, IT equipment was supported by an uninterrupted power supply that was tested periodically, an alternative processing site was identified, critical data were routinely backed up and stored off-site, password controls were adequate, access privileges were terminated when employees left the healthcare system, and computer security awareness training was provided as required. Virus protection procedures were consistent with VA policies, and data security controls were effective.

Opportunities for Improvement

Pharmacy Service – Controls, Safeguards, and Security Needed To Be Strengthened

Conditions Needing Improvement. VHA (Veterans Health Administration) requires Pharmacy Service staff to manage medications, particularly controlled substances (CS), to ensure patient safety and prevent diversion. Each facility is required to have a CS inspection program to certify the accuracy of records and inventory. In addition, VA policy requires specific physical conditions to ensure pharmacy security. To assess CS controls, inspection procedures, and pharmacy security, we interviewed pharmacy staff, inspected CS storage areas, and reviewed pharmacy procedures. We also interviewed the CS Inspection Coordinator and inspectors and observed an unannounced CS inspection conducted in the central pharmacy. We identified three deficiencies that needed to be addressed.

Medication Accountability Policies and Procedures. VHA policy requires that CS inventory discrepancies be recorded and investigated to determine the cause of the discrepancies. However, the local policy did not include procedures for pharmacy staff to follow if discrepancies were identified during CS counts. We also found that pharmacy staff had not conducted biennial pharmacy inventory counts within the past 2 years, as required by VHA policy.

VHA policy requires inspectors to review ledgers and count CS that were unusable due to damage or expiration during their monthly CS inspections. However, during our observation of the unannounced inspection of the central pharmacy, inspectors failed to check the bags of unusable CS.

Prescriptions Safeguards. VHA policy requires that prescriptions arrive at the pharmacy with the patient's full name, address, and social security number. However, prescriptions for medications, including CS, arrived at the central pharmacy for processing without these required items, thus increasing the risks of medication dispensing errors and drug diversion.

Pharmacy Security. VA policy specifies several requirements intended to deter theft and diversion. We identified the following deficiencies that needed to be addressed:

- The central pharmacy vault lacked VA-required reinforcements in the ceiling and vent areas to prevent unauthorized access. In addition, a skylight in the pharmacy was not secured.

- VA policy requires that the volume of the pharmacy alarm be between 80-90 decibels within the configuration of the protected area to deter intruders and alert others to possible unauthorized entry. During our test of the pharmacy's alarm system, the volume and pitch of the alarm were so low that we did not consider it to be an effective deterrent or warning system.

- The electronic entry system for the central pharmacy did not meet VA requirements for monitoring and controlling access. The electronic entry system could not be programmed to limit access to specific areas within the central pharmacy or to limit access by employee or shift. The system also could not generate access records with periodic or on-demand printouts of the times and dates individuals accessed the central pharmacy and vault areas.

The Pharmacy Service Chief agreed with the findings and stated that a lack of continuity in Pharmacy Service management between August 2001 and December 2003 contributed to the identified deficiencies.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Acting Healthcare System Director improves Pharmacy Service accountability and security by requiring that: (a) local CS and pharmacy accountability policies, procedures, and the CS inspection program comply with VHA policy; (b) prescriptions arrive at the Pharmacy Service with the full patient name, address, and social security information; and (c) pharmacy physical security meets VA standards.

The VISN and Acting Healthcare System Directors concurred with the findings and recommendations and made plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Equipment Accountability – Inventory Counts Needed To Be Conducted and Inventory Lists Needed Updating

Conditions Needing Improvement. Healthcare system managers needed to improve inventory controls to ensure adequate accountability for nonexpendable equipment (items costing more than $300 with an expected useful life of more than 2 years). At the healthcare system, Facility Management Service (FMS) staff were responsible for coordinating equipment inventory list (EIL) counts and updating EIL records. Healthcare system staff assigned responsibility for maintaining EILs were required to perform inventory counts and report to FMS when equipment was transferred or excessed.

To determine if equipment inventory controls were effective, we reviewed local policies and procedures, EILs, a judgment sample of 39 equipment items, records of delinquency notices, and Reports of Survey for missing items. We located the 39 sampled equipment items shown on the

EILs, and determined that policies and controls for nonexpendable loaned equipment complied with VHA policy. However, we identified three deficiencies that needed to be addressed.

Timeliness of EIL Counts. As of February 2004, the healthcare system had 75 EILs containing 1,353 line items valued at approximately $21 million. In FY 2003, 39 of the 75 (52 percent) EIL counts had not been performed as required by VHA policy. In addition, six scheduled EIL counts had not been completed in FY 2002. The required EIL counts had not been performed during FY 2003 because the FMS Manager suspended them during the healthcare system's relocation. The FMS Manager was not aware of VHA policy that states that a scheduled inventory count may only be waived for extraordinary reasons, such as natural disasters, and that an extension, not to exceed 60 days, for completing the counts may only be approved by the facility director.

Timeliness of Notifications. VHA policy states that FMS must notify responsible officials whenever an EIL is not counted within 10 days after receipt of the notice to conduct a physical count of the listed nonexpendable property, or 20 days if the EIL contains 100 or more line items. However, FMS staff did not send responsible officials delinquent notices when EIL counts were not performed as scheduled.

Reporting Missing Equipment. VHA policy requires FMS staff to prepare a Report of Survey when an end user reports missing equipment so that VA police can promptly investigate the possible theft of equipment. However, FMS staff did not submit Reports of Survey to the police but simply created a separate EIL to track missing equipment. At the time of this review, the EIL for missing equipment indicated that 11 items of equipment, valued at approximately $126,000, were missing. Because Reports of Survey for the missing equipment were not submitted, we were not able to determine the length of time the equipment had been missing.

The FMS Manager attributed these deficiencies to the decentralization of the healthcare system to 11 different physical locations and a shortage of FMS staff.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Acting Healthcare System Director improve equipment accountability by requiring: (a) the completion of all outstanding EIL physical counts for FYs 2002 and 2003, (b) delinquent notices be sent out to responsible officials who are late in completing their EIL physical counts, and (c) FMS staff promptly submit Reports of Survey for missing equipment.

The VISN and Acting Healthcare System Directors concurred with the findings and recommendations and made plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Supply Inventory Management – The Generic Inventory Package Needed To Be Fully Implemented to Manage Medical Supplies

Conditions Needing Improvement. Prosthetics supply inventory controls were in place and generally operating in compliance with VHA policy. However, healthcare system managers needed to make better use of automated inventory controls to more effectively manage the medical supply inventory. VHA policy established a 30-day supply goal and requires that medical facilities use VA's automated GIP to manage the supply inventory. However, Materiel Management managers had not implemented GIP and staff did not have accurate manual medical supply inventory records. If GIP had been properly implemented, staff would have been able to maintain accurate inventory records, establish appropriate stock levels, analyze usage patterns to determine optimum order quantities and reorder points, and conduct periodic physical inventory counts.

To determine the accuracy of reported medical supply inventory levels, we selected a judgment sample of 20 line items and compared actual quantities on hand to quantities reported in the manual inventory system. Our review showed that the quantities reported were inaccurate for 12 of the 20 (60 percent) items. Because managers had not implemented GIP and manual inventory records were inaccurate, we could not determine the value of stock on hand or the value of excess stock for the entire medical supply inventory.

The manager attributed the deficiencies to the decentralization of the healthcare system and a reorganization of staff. Managers acknowledged the need to implement GIP and have begun entering medical supply inventory line items into GIP.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Acting Healthcare System Director: (a) performs a complete physical inventory count of all medical supply items to determine the actual quantities and values of stock on hand, (b) adjust recent entries in GIP to reflect the actual quantities, (c) complete implementation of GIP in accordance with VHA policy, and (d) ensure that medical supply inventory amounts are consistent with current operating needs and the 30-day supply goal.

The VISN and Acting Healthcare System Directors concurred with the findings and recommendations and made plans for improvement, which are acceptable. We will follow up on planned actions until they are completed.

Medical Care Collections Fund – Coding, Billing, Collection Procedures, and Clinical Documentation Needed Improvement

Conditions Needing Improvement. Under the MCCF Program, VA is authorized to recover from health insurance companies the cost of treating insured veterans. For FY 2003, the

healthcare system collected $8,606,145 (112 percent of the FY 2003 collection goal of $7,214,627). We identified four areas that needed to be addressed.

Coding and Billing Accuracy. The Health Information Management (HIM) Supervisor needed to ensure that bills sent to insurers for collection contained accurate medical diagnostic and procedure codes. To verify the accuracy of coding, we reviewed patient medical records corresponding to 20 unpaid bills valued at $234,246. We verified coding errors detected by the HIM staff on 13 of the 20 bills (65 percent) and found that 6 of the errors affected the bills. Five bills were assigned diagnostic and procedure codes with higher reimbursement values than what was supported by the medical record documentation. As a result, these bills were overstated by $1,725. The remaining bill had been assigned codes with a lower reimbursement value, resulting in the bill being understated by $425. These coding errors caused the 6 bills to be overstated by the net amount of $1,300 ($1,725 - $425). The HIM Supervisor attributed the errors to an inexperienced staff and stated that as the staff become more proficient, the coding and billing error rate would decrease.

Third-Party Insurance Information. Eligibility and clinic clerks are required to identify and verify patient insurance information to ensure accurate and current information. We found that clinic clerks did not consistently update insurance information during patients' follow-up visits. While observing the registration process at five clinics, we found that the electronic check-in process did not include a procedure for verifying and updating patients' insurance information. The MCCF Coordinator acknowledged the limitation of the electronic check-in process and agreed to implement a procedure requiring clinic clerks to manually verify and update insurance information during patients' clinic visits.

MCCF Accounts Receivable. As of January 1, 2004, the healthcare system had 5,941 MCCF accounts receivable with a total value of $1,639,083. Of these, 1,523 MCCF accounts receivable with a value of $247,681 (15 percent of the total value) were more than 90 days old. To evaluate the collection potential for receivables more than 90 days old, we reviewed 50 bills valued at $59,187. After sending the bills, MCCF staff did not routinely make follow-up calls to insurers to determine why payments had not been made. Of the 50 bills, only 10 (20 percent) received appropriate follow-up actions within 30 days, as required. More aggressive collection actions were needed, including sending multiple collection letters and following up with telephone calls. The MCCF Coordinator assured us that the recent recruitment of three additional staff would address this deficiency.

Clinical Documentation. Complete medical record documentation is needed for several reasons, including coordination of care and billing. VA policy requires that clinicians document the care provided in the patients' medical records. Also, attending physicians were required to provide and document resident supervision by countersigning residents' progress notes.

In September 2003, HIM staff identified 40 outpatient care encounters that had missing or insufficient documentation. We reviewed 24 of these encounters and identified several opportunities for improvement. Physicians had dictated their notes for 10 of the encounters, but the HIM staff had not attached the transcribed notes to the patients' charts, as required, and the

notes were no longer available. In eight of the encounters, clinical documentation was either missing or insufficient to support billing. Attending physicians had not countersigned the resident physicians' notes for five encounters, which in September was required for billing. One encounter contained sufficient medical record documentation, but staff did not ensure that a bill for $217 was issued.

More complete medical record documentation and improved coding and billing processes would have resulted in increased reimbursements. If all 40 encounters had sufficient clinical documentation available for billing, the facility could have potentially collected an additional $13,000 in revenue. The Compliance Officer, HIM Supervisor, and the MCCF Coordinator agreed with our findings and assured us that they will address the identified vulnerabilities.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director requires that: (a) all bills contain accurate diagnostic and procedure codes, (b) clinic clerks verify and update patient insurance information, (c) MCCF staff aggressively pursue receivables, (d) all transcribed notes are attached to the patients' records, (e) controls are established to ensure physicians document all patient encounters, (f) attending and resident physicians comply with current resident supervision documentation requirements, and (g) the MCCF Coordinator issue a bill for the identified encounter that had sufficient medical documentation.

The VISN and Acting Healthcare System Directors concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Quality Management – Several Program Areas, Review Processes, and Shared QM Activities Needed Improvement

Conditions Needing Improvement. Most of the QM program elements were operating satisfactorily and providing effective oversight of patient care quality. However, managers and program coordinators needed to significantly improve two program areas, Medication Management and Patient Complaints, and to strengthen review processes overall. To evaluate the healthcare system's QM program, we reviewed 12 specific program areas, such as performance improvement teams, root cause analyses (RCA), and patient complaints. For each area, we assessed various review processes, such as data analysis, benchmarking, and use of evaluation criteria. We interviewed pertinent employees and reviewed policies, plans, committee minutes, and investigation reports. We also reviewed meeting minutes where QM activities were reported at selected MOFH joint councils.

Medication Management. We found that managers had not performed detailed medication management reviews for several months. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require ongoing reviews of medication usage processes. Healthcare system managers acknowledged this finding and discussed their corrective plan, which had been initiated prior to the visit.

Patient Complaints. While we found that patient complaints had been categorized into broad topic areas, such as coordination of care, more detailed analyses had not been conducted to identify meaningful trends. Also, the program coordinator did not consistently present specific patient complaints data in a forum for discussion and action by clinicians. We did not find that conclusions or recommendations were made to address problem areas. VHA policies require that patient complaints data be critically analyzed and improvements acted upon as appropriate. Healthcare system managers agreed that the program could be strengthened.

QM Review Processes. We found that all programs needed more consistent use of benchmarks and evaluation criteria, and improved implementation and evaluation, as required by accreditation standards.

- Service chiefs and program coordinators did not consistently use available benchmarks in data analyses. For example, they had not documented the use of benchmarks in review areas such as medical records, utilization management, or outcomes from resuscitation.

- Managers had identified criteria to use in determining whether corrective actions were effective in RCAs. However, they needed to identify outcome criteria for actions in all QM monitoring activities, as required by accreditation standards. For example, they had not consistently defined evaluation criteria in review areas such as performance improvement teams, patient falls, or utilization management.

- We found that managers and program coordinators did not consistently document appropriate interventions or follow-up on concerns identified in various review activities. For example, medical record reviews identified that verbal orders were confirmed in writing only 76 percent of the time. However, there were no assigned action items or target dates to demonstrate that corrective actions had been planned or implemented. Subsequent reports did not indicate whether any change occurred.

Documentation of Shared QM Activities. While we found clear evidence that MOFH clinicians conducted QM review activities, the chosen topics were conventional, such as tissue review. In VHA medical facilities, including the healthcare system, review topics focus more on complex interdisciplinary processes, such as the way patients are selected and prepared for surgery. Also, in the joint council meeting minutes we reviewed, we did not find documentation of data analysis or trending, benchmarking, use of evaluation criteria, or implementation and evaluation. System managers told us that they have had recent success in working together with MOFH managers to choose progressive review topics to meet JCAHO's staffing effectiveness standards. Similar collaboration in all QM review areas would promote continuous quality improvement at the MOFH.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director implements procedures to: (a) critically analyze and act on data from the Medication Management and Patient Complaints programs; (b) consistently use available benchmarks for analyzing all QM data; (c) define evaluation criteria for all identified corrective actions; (d) implement, evaluate, and document all corrective actions until problems

are resolved or the desired improvements are accomplished; and (e) work with MOFH leadership to improve QM review topic selection, review processes, and documentation.

The VISN and Acting Healthcare System Directors concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Moderate Sedation – Patient Assessments and Documentation Needed Improvement

Conditions Needing Improvement. We found that not all patients scheduled to receive moderate sedation were evaluated within 30 days prior to the procedure or re-evaluated immediately before receiving moderate sedation, as required. To review the management of moderate sedation, we reviewed policies and procedures, patient medical records, and provider credentialing and training files. We also interviewed pertinent employees and inspected areas where moderate sedation is administered.

The healthcare system policy states that clinicians will perform and document pre-procedure medical evaluations on all patients undergoing deep or moderate sedation within 30 days prior to the procedure. The policy also states that clinicians will perform and document a re-evaluation of the patient immediately before the administration of sedation. We selected a sample of 10 patients and found that only 1 patient had a pre-procedure medical evaluation within 30 days of the procedure documented in the medical record, and only 6 patients had documented re-evaluations immediately prior to sedation administration.

Healthcare system managers had identified these deficiencies and initiated changes. They provided evidence to show that, since January 2004, clinicians have performed and documented medical evaluations within 30 days prior to procedures involving moderate sedation. A standardized documentation template developed for patient re-evaluation was pending approval from the Medical Records Committee.

Suggested Improvement Actions. We suggested that the VISN Director and the Acting Healthcare System Director take action to ensure that clinicians consistently perform and document the following for patients having moderate sedation: (a) medical evaluations within 30 days prior to procedures and (b) re-evaluations immediately before the administration of moderate sedation.

The VISN and Acting Healthcare System Directors concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Service Contracts – Contract Award Administration and Documentation Needed To Be Strengthened

Conditions Needing Improvement. VISN 22 has a centralized Network Business Center (NBC), which coordinates contracting activities for all VISN 22 facilities. NBC Contracting Officers needed to improve contract award administration and documentation. To determine the effectiveness of contract award procedures and contract administration, we reviewed a judgment sample of 10 contracts (7 contracts valued at about $10,961,000 and 3 blanket purchase agreements with no fixed total contract value). We identified two deficiencies that needed to be improved.

Contract Award Documentation. The Federal Acquisition Regulation states that contracting officers must, at a minimum, use price analysis to determine whether the price is fair and reasonable and document the principal elements of the negotiated agreement in the file. Of the 10 files reviewed, 6 contracts did not have contract price analysis documentation in the files and 1 contract did not document that a fair and reasonable price was obtained.

Contracting Officer's Technical Representative Designations. For each contract, a Contracting Officer's Technical Representative (COTR) should be designated by the Contracting Officer in writing to monitor contractor performance and ensure that services are provided in accordance with the contract terms. We found that 5 of the 10 contract files did not contain letters designating COTRs, although healthcare system staff were fulfilling COTR responsibilities. The staff were aware that they were the designated COTRs, despite the absence of appointment letters in the files.

Suggested Improvement Actions. We suggested that the VISN Director ensure that NBC Contracting Officers: (a) prepare price analyses for negotiated acquisitions and include statements of price reasonableness in the contract files and (b) designate all COTRs in writing and include copies of the designations in the contract files.

The VISN Director concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Appendix A

VISN 22 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 9, 2004

From: VISN Director

Subject: Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada – Project Number 2004-00489-HI-0056

To: Director, Operational Support Division (53B)

Thru: Director, VHA Management Review and Administration Service (105E)
Administrative Investigations Division (51Q)

1. The attached provides a status report regarding the above OIG report 2004-00489-HI-0056.

2. Should you have questions, please contact Teresa Osborn, Quality Management Officer
(562) 826-5963.

(*original signed by:)*
Kenneth J. Clark, FACHE

Attachment

Appendix B

VA Southern Nevada Healthcare System Director Comments

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

VA Southern Nevada Healthcare System (VASNHS)
Comments and Action Implementation Plan

RECOMMENDED IMPROVEMENT ACTIONS

Pharmacy Service

The Office of Inspector General (OIG) recommends VISN Director ensure that the Acting Healthcare System Director improves Pharmacy Service accountability and security by requiring that: (a) local controlled substance (CS) and pharmacy accountability policies, procedures, and the CS inspection program comply with VHA policy; (b) prescriptions arrive at the Pharmacy Service with the full patient name, address, and social security information; and (c) pharmacy physical security meets VA standards.

A. Medication Accountability Policies and Procedures

Finding: VHA policy requires that CS inventory discrepancies be recorded and investigated to determine the cause of the discrepancies. However, the local policy did not include procedures for pharmacy staff to follow if discrepancies were identified during CS counts. We also found that pharmacy staff had not conducted biennial pharmacy inventory counts within the past 2 years, as required by VHA policy.

VASNHS concurs with recommended improvement action:

a. VASNHS implemented the controlled substance package during the week of February 17, 2004 and is in the process of revising the controlled substance memorandum to incorporate these new procedures. The pharmacy does have procedures in place if a discrepancy is identified. Currently, only the Chief of Pharmacy and Lead Pharmacist have the ability to institute a balance correction. All discrepancies are researched and certified by either the Chief of Pharmacy or Lead Pharmacist. This procedure was demonstrated to the OIG inspector during the unannounced controlled substance inspection on the week

of February 23, 2004. Pharmacy will work to revise the controlled substance policy to meet current practice procedures. Target date: May 31, 2004.

b. VASNHS has not conducted a biennial review because of multiple changes in Pharmacy leadership. This was addressed prior to the OIG visit. An initial inventory was completed on February 5, 2004, and future inspections will be scheduled accordingly. The biennial inventory will be formalized in the update of the controlled substance policy. In addition, VASNHS has approved the purchase of an Omnicell Narcotic Vault, which will streamline the accountability of controlled substances and assure biennial inventory counts. Target date: May 31, 2004.

Finding: VHA policy requires inspectors to include ledgers and sealed bags of CS that were unusable due to damage or expiration during their monthly CS inspections. However, during our observation of the unannounced inspection of the central pharmacy, inspectors failed to check the bags of unusable CS.

VASNHS Concurs with recommended improvement action: The controlled substance coordinator will conduct an inservice with inspectors to ensure that the ledger and sealed bags of controlled substances are inspected during their monthly inspections. A standardized checklist will be developed to ensure that all components of the inspection have been completed. Target date: May 31, 2004.

B. Prescriptions Safeguards

Findings: VHA policy requires that prescriptions arrive at the pharmacy with the patient's full name, address, and social security number. However, prescriptions for medications, including CS, arrived at the central pharmacy for processing without these required items, thus increasing the risks of medication dispensing errors and drug diversion.

VASNHS concurs with recommended improvement action: The Chief of Staff sent a memorandum addressing this issue on March 2, 2004, to all providers. Pharmacy Service is now collecting data on providers that are not in compliance with this memorandum and working with administration to ensure compliance. Target date: Completed.

C. Pharmacy Security

Finding: The central pharmacy vault lacked VA-required reinforcements in the ceiling and vent areas to prevent unauthorized access. In addition, a skylight in the pharmacy was not secured.

VASNHS concurs with recommended improvement action: This issue was identified prior to the OIG visit and is in the process of being corrected. In the interim, 24-hour security has been implemented at the Business Center (location of main Pharmacy) until this issue is corrected. Target date: April 26, 2004.

Finding: VA policy requires that the volume of the pharmacy alarm be between 80-90 decibels within the configuration of the protected area to deter intruders and alert others to possible unauthorized entry. During our test of the pharmacy's alarm system, the volume and pitch of the alarm were so low that we did not consider it to be an effective deterrent or warning system.

VASNHS concurs with recommended improvement action: VASNHS will replace the siren with one that will emit an alarm to meet the required specifications (80-90 decibels) at all pharmacy locations. Target date: May 31, 2004.

Finding: The electronic entry system for the central pharmacy did not include VA required specifications for monitoring and controlling access. The electronic entry system could not be programmed to limit access to specific areas within the central pharmacy or by user based on their shift. The system also could not generate access records with periodic or on-demand printouts of the times and dates individuals accessed the central pharmacy and vault areas.

VASNHS concurs with recommended improvement action: VASNHS will upgrade the electronic entry system to conform with this requirement. Target date: May 31, 2004.

Equipment Accountability

The OIG recommends that the VISN Director ensure that the Acting Healthcare System Director improve equipment accountability by requiring: (a) the completion of all outstanding equipment inventory list (EIL) physical counts for FYs 2002 and 2003, (b) delinquent notices be sent out to responsible officials who are late in completing their EIL physical counts, and (c) Facility Management Service (FMS) staff promptly submit reports of survey for missing equipment.

A. Timeliness of EIL Counts

Finding: As of February 2004, the healthcare system had 75 EILs containing 1,353 line items valued at approximately $21 million. In FY 2003, 39 of the 75 (52 percent) EIL counts had not been performed as required by VHA policy. In addition, six scheduled EIL counts had not been completed in FY 2002. The required EIL counts had not been performed during FY 2003 because the FMS Manager suspended them during the healthcare system's relocation. The FMS Manager was not aware of VHA policy that states that a scheduled inventory count may only be waived for extraordinary reasons such as natural disasters and that an extension, not to exceed 60 days, for completing the counts may only be approved by the facility director.

VASNHS concurs with recommended improvement action: Completion of all outstanding EIL physical counts for FYs 2002 and 2003: The remaining twenty-two outstanding EIL physical counts will be completed by May 1, 2004. VASNHS has implemented a revised EIL review schedule and updated the policy to reflect these changes, Medical Center Memorandum 138-01-24, Inventory of Non-expendable Government Property. Senior management will

monitor compliance with this policy on a monthly basis through our Executive Leadership Board as a standing agenda item. Target date: May 31, 2004.

B. Timeliness of Notifications

Finding: VHA policy states that FMS must notify responsible officials whenever an EIL is not counted within 10 days after receipt of the notice to conduct a physical count of the listed nonexpendable property, or 20 days if the EIL contains 100 or more line items. However, FMS staff did not send responsible officials delinquent notices when EIL counts were not performed as scheduled.

VASNHS concurs with recommended improvement action: VASNHS will implement a revised EIL process to ensure compliance. The policy concerning the EIL inventory process, Medical Center Memorandum 138-01-24, Inventory of Non-expendable Government Property, will be revised to include a requirement for delinquent notices. Senior management will monitor compliance with this policy on a monthly basis through our Executive Leadership Board as a standing agenda item. Target date: May 31, 2004.

C. Reporting Missing Equipment

Finding: VHA policy requires FMS staff to prepare a report of survey when an end user reports missing equipment so that VA police can promptly investigate the possible theft of equipment. However, FMS staff did not submit reports of survey to the police but simply created a separate EIL to track missing equipment. At the time of this review, the EIL for missing equipment indicated that 11 items of equipment, valued at approximately $126,000, were missing. Because reports of survey for the missing equipment were not submitted, we were not able to determine the length of time the equipment had been missing.

VASNHS concurs with recommended improvement action: Report of surveys for all missing equipment will be initiated and forwarded to the Director for appointment of a Survey Officer or Board of Survey and subsequent investigations. The policy concerning the report of survey process, Medical Center Memorandum 02-03-07, Report of Survey, will be revised to clarify report of survey responsibilities and strengthen the process. Target date: June 1, 2004.

Supply Inventory Management

The OIG recommends that the VISN Director ensure that the Acting Healthcare System Director: (a) performs a complete physical inventory count of all medical supply items to determine the actual quantities and values of stock on hand, (b) adjust recent entries in the Generic Inventory Package (GIP) to reflect the actual quantities, (c) complete implementation of the GIP in accordance with VHA policy, and (d) ensure that medical supply inventory amounts are consistent with current operating needs and the 30-day supply goal.

A. Physical Inventory Count

Findings: Healthcare system managers needed to make better use of automated inventory controls to more effectively manage the medical supply inventory. VHA policy established a 30-day supply goal and requires that medical facilities use VA's GIP to manage the supply inventory. However, Materiel Management (MM) managers had not implemented GIP and MM staff did not have accurate manual medical supply inventory records.

VASNHS concurs with recommended improvement action: VASNHS will implement GIP and appropriate processes to manage the supply inventory. Senior management will monitor compliance with this new initiative on a monthly basis through our Executive Leadership Board as a standing agenda item. Target date: June 1, 2004.

B. Actual Quantities

Findings: If GIP had been properly implemented, MM staff would have been able to maintain accurate inventory records, establish appropriate stock levels, analyze usage patterns to determine optimum order quantities and reorder points, and conduct periodic physical inventory counts.

VASNHS concurs with recommended improvement action: VASNHS will implement GIP and appropriate processes to manage the supply inventory. Senior management will monitor compliance with this new initiative on a monthly basis through our Executive Leadership Board as a standing agenda item. Target date: June 1, 2004.

C. Complete Implementation of GIP

Findings: MM managers had not implemented GIP, or any other formal inventory system, we could not determine the value of stock on hand or the value of excess stock for the entire medical supply inventory.

VASNHS concurs with recommended improvement action: VASNHS will implement GIP and appropriate processes to manage the supply inventory. Senior management will monitor compliance with this new initiative on a monthly basis through our Executive Leadership Board as a standing agenda item. Target date: June 1, 2004.

D. Medical Supply Inventory

Findings: Medical supply inventory amounts are non consistent with current operating needs and the 30-day supply goal.

VASNHS concurs with recommended improvement action: VASNHS will identify space and relocate SPD operations to allow management of a 30-day stock level. Target date: June 1, 2004.

SUGGESTED IMPROVEMENT ACTIONS

Medical Care Collections Fund

The OIG suggests that the VISN Director ensure that the Acting Healthcare System Director requires that: (a) all bills contain accurate diagnostic and procedure codes, (b) clinic clerks verify and update patient insurance information, (c) MCCF staff aggressively pursue receivables, (d) all transcribed notes are attached to the patients' records, (e) controls are established to ensure physicians document all patient encounters, (f) attending and resident physicians comply with current resident supervision documentation requirements, and (g) the MCCF Coordinator issue a bill for the identified encounter that had sufficient medical documentation.

A. Coding and Billing Accuracy

Findings: Coding errors detected by the HIM staff on 13 of the 20 bills (65 percent) and found that 6 of the errors affected the bills. Five bills were assigned diagnostic and procedure codes with higher reimbursement values than what was supported by the medical record documentation. As a result, these bills were overstated by $1,725. The remaining bill had been assigned codes with a lower reimbursement value, resulting in the bill being understated by $425.

VASNHS concurs with suggested improvement action: All bills are audited for accuracy prior to submission via an electronic coding system. Target date: April 30, 2004.

B. Verify/Update Patient Insurance Information

Findings: While observing the registration process at five clinics, we found that the electronic check-in process did not include a procedure for verifying and updating patients' insurance information.

VASNHS concurs with suggested improvement action: VASNHS will implement a new patient check-in process to ensure patient demographic and insurance information is current and validated. Target date: May 31, 2004.

C. Third-Party Insurance Receivables

Findings: As of January 1, 2004, the healthcare system had 5,941 MCCF accounts receivable with a total value of $1,639,083. Of these, 1,523 MCCF accounts receivable with a value of $247,681 (15 percent of the total value) were more than 90 days old. To evaluate the collection potential for receivables more than 90 days old, we reviewed 50 bills valued at $59,187.

VASNHS concurs with suggested improvement action: VASNHS will aggressively pursue all active third party receivables. Changes in the process will include: MCCF will manually print and mail the second notice at age 30

days, and MCCF will mail the third notice and follow-up with a phone call to the insurance carrier at age 45 days. All active claims aged 61 days will be referred to our contracted third party collections company for additional follow-up. Target date: May 31, 2004.

D. Clinical Documentation

Findings: Physicians had dictated their notes for 10 of the encounters, but the HIM staff had not attached the transcribed notes to the patients' charts, as required, and the notes were no longer available. In eight of the encounters, clinical documentation was either missing or insufficient to support billing.

VASNHS concurs with suggested improvement action: VASNHS will ensure all transcribed notes will become a part of the permanent record. If the patient is still an inpatient, all notes will be included with data on the ward of admission as soon as completed. Target date: May 31, 2004.

E. Physician Documentation

Findings: In September 2003, HIM staff identified 40 outpatient care encounters that had missing or insufficient documentation. We reviewed 24 of these encounters and identified several opportunities for improvement. Physicians had dictated their notes for 10 of the encounters, but the HIM staff had not attached the transcribed notes to the patients' charts, as required, and the notes were no longer available. In eight of the encounters, clinical documentation was either missing or insufficient to support billing.

VASNHS concurs with suggested improvement action: VASNHS has assigned medical support assistants to review each encounter at 72 hours to ensure that both a progress note and an electronic encounter have been completed. Providers will be given lists on a daily basis of incomplete records and encounter data. Random audits will be performed in each clinic monthly to determine record completion rates. Timely completion of medical records is part of each provider's proficiency review. Target date: April 30, 2004.

F. Resident Supervision Documentation Requirements

Findings: Attending physicians had not countersigned the resident physicians' notes for five encounters which was required for billing.

VASNHS concurs with suggested improvement action: VASNHS will ensure attending physicians countersign resident physician notes. The Compliance Officer will conduct random audits and will report the findings to senior management on a monthly basis. VASNHS will implement new processes to ensure adequate attending physician documentation and oversight. Target date: May 31, 2004.

G. Bill Issued

Findings: One encounter contained sufficient medical record documentation, but staff did not ensure that a bill for $217 was issued.

VASNHS concurs with suggested improvement action: VASNHS will ensure that bills are issued for all identified encounters that have sufficient medical documentation and have been properly coded. All questionable coded encounters will be returned to Coding for review. Target date: May 31, 2004.

Quality Management

The OIG suggests that the VISN Director ensure that the Acting Healthcare System Director implements procedures to: (a) critically analyze and act on data from the Medication Management and Patient Complaints programs; (b) consistently use available benchmarks for analyzing all quality management (QM) data; (c) define evaluation criteria for all identified corrective actions; (d) implement, evaluate, and document all corrective actions until problems are resolved or the desired improvements are accomplished; and (e) work with Michael O'Callahan Federal Hospital (MOFH) leadership to improve QM review topic selection, review processes, and documentation.

A. Analyze Data

a. Medication Management

Finding: Managers had not performed detailed medication management reviews for several months. JCAHO standards require ongoing reviews of medication usage processes. Healthcare system managers acknowledged this finding and discussed their corrective plan, which had been initiated prior to the visit.

VASNHS concurs with suggested improvement action: VASNHS has conducted reviews of the medication usage process; however this data was not being reviewed or acted on by the local pharmaceutical and therapeutic (P&T) Committee. VASNHS has implemented a standardized reporting format and will incorporate medication management reviews as a standing item on the P&T agenda. Target date: completed.

b. Patient Complaint/Customer Service Program

Finding: While we found that patient complaints had been categorized into broad topic areas, such as coordination of care, more detailed analyses had not been conducted to identify meaningful trends. Also, the program coordinator did not consistently present specific patient complaints data in a forum for discussion and action by clinicians. We did not find that conclusions or recommendations were made to address problem areas. VHA policies require that patient complaints data be critically analyzed and improvements acted upon

as appropriate. Healthcare system managers agreed that the program could be strengthened.

VASNHS concurs with suggested improvement action: VASNHS has realigned the Customer Service program organizationally under the Office of Quality & Performance. In an effort to standardize reporting, customer service data will be categorized into specific criteria. Changes in the customer service process and database have occurred to expand the trending and analysis of the data. The new process includes extensive analysis of the data benchmarked against VISN 22 facility and National Patient Satisfaction scores. Action plans based on customer service data analysis will be developed through multidisciplinary teams. Office of Quality & Performance will monitor plans to ensure follow-up and closure. The clinic and provider specific CS data will be aggregated and trended monthly. This information will flow up and down throughout the organization and will be reported at the individual site staff meetings as well as in several Boards, Councils, & Committees. Provider specific customer service information will be shared with clinicians in an interactive forum; Health Insurance Portability and Accountability Act (HIPAA) standards are being followed to ensure privacy. Target date: May 31, 2004.

B, C, & D Benchmarks, Evaluation Criteria, & Corrective actions

Findings: We found that all programs needed more consistent use of benchmarks and evaluation criteria, and improved implementation and evaluation, as required by accreditation standards.

Service chiefs and program coordinators did not consistently use available benchmarks in data analyses. For example, they had not documented the use of benchmarks in review areas such as medical records, utilization management, or outcomes from resuscitation.

Facility managers had identified criteria to use in determining whether corrective actions were effective in RCAs. However, they needed to identify outcome criteria for actions in all QM monitoring activities, as required by accreditation standards. For example, they had not consistently defined evaluation criteria in review areas such as performance improvement teams, patient falls, or utilization management.

We found that facility managers and program coordinators did not consistently document appropriate interventions or follow-up on concerns identified in various review activities. For example, medical record reviews identified that verbal orders were confirmed in writing only 76 percent of the time. However, there were no assigned action items or target dates to demonstrate that corrective actions had been planned or implemented. Subsequent reports did not indicate whether any change occurred.

VASNHS concurs with suggested improvement action: VASNHS will establish mandatory classes for all supervisors and council/committee chairs/members on data performance improvement that will include: data collection, data analysis, use of benchmarks, action planning and evaluation criteria, and improved implementation and evaluation, as required by

accreditation standards. Also, a Performance Improvement/Data Analysis Class will be held quarterly and be open to all facility employees. Target Date: September 1, 2004.

A review of the Improving Organizational Performance Medical Center Memorandum will be completed and any necessary changes made to ensure more consistent use of benchmarks and evaluation criteria, and improved implementation and evaluation, as required by accreditation standards. Target Date: May 1, 2004.

E. MOFH

Findings: While we found clear evidence that MOFH clinicians conducted QM review activities, the chosen topics were conventional, such as tissue review. In VHA medical facilities, including the healthcare system, review topics focus more on complex interdisciplinary processes, such as the way patients are selected and prepared for surgery. Also, in the joint council meeting minutes we reviewed, we did not find documentation of data analysis or trending, benchmarking, use of evaluation criteria, or implementation and evaluation. System managers told us that they have had recent success in working together with MOFH leaders to choose progressive review topics to meet JCAHO's staffing effectiveness standards. Similar collaboration in all QM review areas would promote continuous quality improvement at the MOFH.

VASNHS concurs with suggested improvement action: VASNHS initiated discussion with Air Force leadership and will address the need to collaborate in all QM review areas. This will be discussed at the next scheduled Joint Venture Executive Council meeting. Target date: June 30, 2004.

Moderate Sedation

Findings: The OIG suggests that the VISN Director ensure that the Acting Healthcare System Director takes action to ensure that clinicians consistently perform and document the following for patients having moderate sedation: (a) medical evaluation within 30 days prior to procedures and (b) re-evaluation immediately before the administration of moderate sedation.

VASNHS concurs with suggested improvement action: We found that not all patients scheduled to receive moderate sedation were evaluated within 30 days prior to the procedure or re-evaluated immediately before receiving moderate sedation, as required.

a. A Process Improvement Team (PIT) has been established to develop an improved process, particularly the medical records documentation component in the Endoscopy area. Those areas targeted for improvement are the pre-procedure assessment and the immediate pre-procedure reassessment. The GI Nurse Practitioner will be monitoring and performing regular audits to ensure that all patients have an appropriate pre-procedure assessment within 30 days of their procedure. PIT recommendations will be submitted to the Quality and Performance Improvement Council for approval and action tracking. Target date: June 1, 2004.

b. As part of the Process Improvement Team, the sedation/procedure form is being revised to facilitate improved documentation of the immediate pre-procedure reassessment. This includes assessments by the certified registered nurse anesthetist (CRNA) and the Endoscopist. The form is currently under review by the Medical Records Committee and will implemented once approved. Regular audits of compliance will be performed and reported to the Quality and Performance Improvement Council. Target date: May 1, 2004.

Service Contracts

The OIG suggests that the VISN Director ensure that NBC Contracting Officers: (a) prepare price analyses for negotiated acquisitions and include statements of price reasonableness in the contract files and (b) designate all Contracting Officer's Technical Representatives (COTRs) in writing and include copies of the designations in the contract files.

A. Contract Award Documentation

Findings: The Federal Acquisition Regulation states that contracting officers must, at a minimum, use price analysis to determine whether the price is fair and reasonable and document the principal elements of the negotiated agreement in the contract file. Of the 10 contract files reviewed, 6 contracts did not have contract price analysis documentation in the files and 1 contract did not document that a fair and reasonable price was obtained.

VISN 22 concurs with suggested improvement action: For all future awards, contracting officers will use price analysis, at a minimum, to determine whether the price is fair and reasonable for all. Documentation that a fair and reasonable price was obtained will be included in the contract file. For contracts above the simplified acquisition threshold ($100,000), contracting officers will document the principle elements of the negotiated agreement in the contract file. A Price Negotiation Memorandum will be included in the contract file. Target date: April 30, 2004.

B. Contracting Officer's Technical Representative Designations

Findings: For each contract, a COTR should be designated by the Contracting Officer in writing to monitor contractor performance and ensure that services are provided in accordance with the contract terms. We found that 5 of the 10 contract files did not contain letters designating COTRs, although healthcare system staff were fulfilling COTR responsibilities. The staff was aware that they were the designated COTRs, despite the absence of appointment letters in the files.

VISN 22 concurs with suggested improvement action: VISN 22 will ensure that contracting officers designate a COTR for each contract, and the acquisition supervisor will be required to review contract file within 30 days after contract award and after closeout dates. A policy will be issued for NBC acquisition to implement. Target date: April 30, 2004.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by improving medical record documentation and coding and billing processes.	$13,000

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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