Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Bath, New York

Report No. 04-01096-162

July 2, 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 March 29 – April 2, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Bath, New York. 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 170 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Results of Review

This CAP review focused on 18 areas. As indicated below there were no concerns identified in 14 of the areas. The remaining four areas resulted in recommendations or suggestions for improvement.

The medical center complied with selected standards in the following areas:

- Accounts Receivable
- Accrued Services Payable
- Clinic Waiting Times and Patient Enrollment
- Controlled Substances Accountability
- Environment of Care
- General Post Funds
- Information Technology Security
- Medical Care Collections Fund
- Medical Supplies Inventory
- Personal Funds of Patients
- Pharmacy Security
- Physician Conflicts of Interest
- Quality Management
- Undelivered Orders

We identified four areas that needed additional management attention. To improve operations, the following recommendations were made:

- Strengthen monitoring of contractor performance and improve contract administration.
- Establish controls to strengthen accountability and effectively manage engineering supplies inventory.

A suggestion for improvement was made in each of the following areas:

- Improve the process and documentation of peer reviews.
- Require discussion and agreement in a timely manner by all medical facilities that will be affected by actions resulting from Root Cause Analysis (RCA).

This report was prepared under the direction of Thomas L. Cargill, Jr., Director, and Jacqueline L. Stumbris, CAP Review Coordinator, Bedford Audit Operations Division.

VISN 2 and Medical Center Directors' Comments

The VISN 2 Director and Medical Center Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendixes A and B, pages 7-12 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

Medical Center Profile

Organization. The VA Medical Center Bath, New York is an acute and long term care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics (CBOCs) located in Elmira and Wellsville, New York. The medical center serves a veteran population of about 36,000 in a primary service area that includes seven counties in Pennsylvania and New York.

Programs. The medical center provides medical, surgical, mental health, geriatric, and advanced rehabilitation services. The medical center has 20 hospital beds, 7 observation beds and 160 nursing home beds. The Domiciliary has 220 beds and provides residential rehabilitation services.

Affiliations and Research. The medical center does not have any medical residency positions or research projects.

Resources. In Fiscal Year (FY) 2003, Bath VA Medical Center medical care expenditures totaled $53.4 million. The FY 2004 medical care budget is $56.8 million, 6.4 percent more than FY 2003 expenditures. FY 2003 staffing was 594.7 full-time equivalent employees (FTE), including 16 physician and 171.6 nursing FTE.

Workload. In FY 2003, the medical center treated 11,269 unique patients, a 0.9 percent decrease from FY 2002. The inpatient care workload totaled 1,820 medical and nursing home unit discharges, and the average daily census (ADC), including nursing home patients, was 142. The outpatient workload was 117,198 visits. The Domiciliary workload totaled 522 discharges and the ADC was 182.

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 medical center operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity 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 patient care to identify and correct harmful or potentially harmful practices or 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 2003 and FY 2004 through March 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	Medical Supplies Inventory
Accrued Services Payable	Peer Review Process
Clinic Waiting Times and Patient Enrollment	Personal Funds of Patients
Controlled Substances Accountability	Pharmacy Security
Engineering Supplies Inventory	Physician Conflicts of Interest
Environment of Care	Quality Management
General Post Funds	Root Cause Analysis
Information Technology Security	Service Contracts
Medical Care Collections Fund	Undelivered Orders

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 medical center employees, 93 of whom responded. We also interviewed 25 patients during the review. The surveys indicated generally high levels of patient and employee satisfaction and did not disclose any significant issues. The full survey results were provided to medical center management.

During the review, we presented 4 fraud and integrity awareness briefings that were attended by 170 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.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-6). 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 Opportunities for Improvement section, there were no reportable deficiencies identified.

Results of Review

Opportunities for Improvement

Service Contracts – Administration Needed Improvement

Condition Needing Improvement. VISN and medical center management needed to strengthen contract administration. To determine if contracts were properly administered, we reviewed a sample of 5 VISN and 5 medical center current service contracts valued at approximately $4.5 million and $2.5 million, respectively.

VISN Contracts

- Eyeglass orders need justification. The Contracting Officer's Technical Representative (COTR) responsible for monitoring a VISN eyeglass contract valued at $750,000 did not ensure that the optometrist placing eyeglass orders justified the procurement of special lenses (e.g., no-line progressive, transition, and tinted lenses). VA policy states that special lenses may be procured if medical need exists and the need is documented. From April 6, 2003 to March 31, 2004, the medical center purchased 2,115 pairs of eyeglasses valued at $136,296. Of these 2,115 purchases, 1,072 (51 percent) had special lenses. The total cost of these 1,072 pairs of eyeglasses was $94,575. To determine if medical need for special lenses was documented in the patients' records, we reviewed a judgment sample of 20 purchases of eyeglasses with special lenses valued at $2,370. The optometrist had not provided written justifications of the medical need for special lenses in 19 of the 20 purchases (95 percent). Special lenses for the 19 purchases totaled $1,400. The cost of these lenses accounted for 59 percent ($1,400/$2,370) of the total value of the sample. Applying this percentage to the total cost of eyeglasses with special lenses, we estimate that the medical center purchased $55,799 ($94,575 x 59 percent) in special lenses without justifications of medical need.

- Database searches needed to be conducted. Contracting officers did not conduct database searches of the Excluded Party Listing System (EPLS) for two VISN contracts prior to awarding the contracts. The Federal Acquisition Regulation (FAR) requires that contracting officers conduct searches of the EPLS to determine if prospective contractors are eligible for Federal contracts. One of the contracts provided for pick-up and delivery services of Government-owned durable medical equipment (DME), and the second contract provided for home health care (HHC) services. The DME contract, valued at $934,000, began on July 1, 1999. The HHC contract, valued at $82,000, began on August 1, 2003. At our request, the contracting officers conducted EPLS database searches of the relevant contractors and they were found to be eligible for Federal contracts.

- Technical reviews of contracts exceeding $500,000 were needed. A contracting officer did not forward the DME contract, an indefinite delivery, indefinite quantity (IDIQ) contract, to the VA Office of Acquisition and Material Management (OA&MM) for a technical review prior to contract execution. VA policy requires that multi-year IDIQ contracts exceeding a value of $500,000, inclusive of option years, undergo a technical review.

- Justification for option years was needed. Contracting officers did not document written justifications in accordance with the FAR to exercise option years for two VISN contracts (the DME contract and a second contract for home oxygen services). The home oxygen service contract, valued at $2.2 million, began on February 1, 2000.

Medical Center Contracts

- Closer monitoring of contract providers' credentials was needed. The COTR responsible for monitoring a CBOC contract did not obtain evidence nor verify licensure for two contracted employees, a Registered Nurse (RN) and a Licensed Practical Nurse (LPN). The contract, valued at $459,000, began on October 1, 2003. The RN and LPN began providing services at the CBOC on March 4 and 5, 2004, respectively. The contract required clinical staff to provide primary/preventative services at the Wellsville CBOC. The RN and LPN were required to possess current and unrestricted licenses issued by the State of New York. We requested and received evidence of licensure from the contractor for the RN and LPN on March 30, 2004. The medical center's Credentialing Coordinator verified that the licenses were current and unrestricted and that no disciplinary actions were found.

- Background investigations of contract providers needed to be initiated sooner. VA policy requires that background investigations for contractor personnel with access to VA computer systems and sensitive information be initiated prior to contract performance. Contracting officers did not initiate background investigations for the RN and LPN providing primary/preventative care at the Wellsville CBOC and for eight physicians designated as the medical officers of the day (MODs) providing off-hour coverage for the medical center. The MOD contract, valued at $1.8 million, began on March 21, 2003. Background investigations were initiated as a result of our inquiry, 1 month after the RN and LPN began providing services and 12 months after the MOD contract began.

Recommended Improvement Action 1. We recommended that the VISN and Medical Center Directors ensure that VISN and medical center contracting officials take action to: (a) document medical need to justify the procurement of special eyeglass lenses, (b) conduct database searches of EPLS prior to awarding contracts, (c) forward contracts, when appropriate, to the OA&MM for technical reviews prior to contract execution, (d) document justifications to exercise option years of contracts, (e) verify appropriate licensure for contract CBOC employees, and (f) initiate background investigations for contractor personnel with access to VA computer systems and sensitive information prior to contract performance.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the VISN Network Contracting Activity (NCA) would conduct a meeting in June 2004, to formulate a network-wide contract checklist. A review of contracts will be conducted throughout VISN 2 to ensure that all contracts comply with FAR, VA Acquisition Regulations, and other directives, policies, and requirements. Remedial COTR training will be provided regarding the scope of work contained in the contract and appropriate documentation of medical files. COTRs will audit medical files to ensure appropriate documentation is included. The Network Contract Manager will complete audits of contract files on an annual basis. Training will be conducted regarding technical review requirements, documentation needed to exercise option years of contracts, and appropriate documentation of contract personnel. The

improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Engineering Supplies Inventory – Controls Needed to be Strengthened

Condition Needing Improvement. Medical center management needed to establish controls to strengthen accountability and effectively manage engineering supplies inventory. Annual inventories should be conducted to strengthen accountability. Implementing the Generic Inventory Package (GIP) will provide effective management of engineering supplies. Veterans Health Administration (VHA) mandated the use of GIP in October 2000 and also set a goal to reduce supply inventories to a 30-day level. The GIP is an automated management tool that assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand. While the GIP was in use in other areas of the medical center, it was not being utilized in the engineering section of Facilities Management Service (FMS). Because of the manner in which supplies were maintained, it was not possible to readily identify whether engineering supplies currently on-hand were overstocked or adequate to meet medical center needs.

Engineering supplies include all parts, tools, and other supplies used for maintaining and repairing equipment, buildings, furnishings, utility systems, and grounds. During FY 2003, the medical center spent $271,889 on expendable engineering supplies. VHA policy requires that engineering supplies be inventoried annually. The respective shop foremen completed inventories of the eight engineering shops for the first time on March 1, 2004. To verify the accuracy of the engineering supplies inventory, we reviewed the inventory listings of the paint, electric, plumbing, and carpenter shops, and the boiler plant. We selected a judgment sample of 12 engineering supplies items valued at $9,677 from a universe of 3021 line items valued at $289,541. For 3 of the 12 items, the quantities listed were inaccurate. In addition, the inventory method being used by the engineering staff was not effective in establishing normal stock levels, reorder point levels, and emergency stock levels or evaluating item usage rates to manage engineering supply inventory. We noted the stated value of engineering supplies currently on-hand ($289,541) exceeded the total value of purchases for FY 2003 ($271,889), possibly indicating an excess of supplies. However, we were unable to determine the value of the excess supplies. We discussed the need to implement GIP and the opportunities to identify excess inventory with the VISN and Medical Center Directors and they agreed to report back to the OIG any savings resulting from reducing the inventory of engineering supplies.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires FMS management to conduct annual inventories, implement GIP to control engineering supplies, reduce inventory levels, and report back any resultant savings.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that annual inventories will be conducted and implementation of GIP would be completed by January 1, 2005. Staff will work to reduce inventory, and management will report back to the OIG any savings resulting from reducing inventory levels. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Peer Review Process – Process Needed Improvement

Condition Needing Improvement. We reviewed 10 peer review records and the minutes of the Peer Review Committee for the first and second quarters of FY 2004. We found that standards of care had not been identified and used to ensure objective assessments of cases, and peer reviewer analysis of the cases was not properly documented as required by VA and VISN policy. Neither the records nor the committee minutes gave a comprehensive analysis of criteria used for basing decisions/outcomes. In one case, findings were appealed. Appeal letters from providers were based on opinion rather than on standards or analysis using clinical expertise.

We discussed the process with the Chief of Staff, Performance Improvement Coordinator, Risk Manager, and the Medical Center Director. The peer review process had been identified by clinical leadership as an area needing improvement prior to our CAP review. A satisfactory action plan was furnished to us during our review.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Medical Center Director monitors the implementation and effectiveness of the peer review action plan.

The VISN and Medical Center Directors agreed with the findings and suggestion. The Peer Review Committee is re-creating the process at the medical center using standards of care set by local policies, national policies, and VHA "Clinical Practice Guidelines" as well as other nationally accepted principles of practice. The committee will ensure that each review will be screened by a peer and that the peer will be in attendance when the case is discussed.

Root Cause Analysis – Timeliness Needed Improvement

Condition Needing Improvement. The VISN requested a RCA to investigate a delay in transferring a patient who had a parasuicidal event that required a level of psychiatric care not available at the medical center. The delay in transferring the patient to another facility within the VISN resulted in keeping the patient in four-point leather restraints for approximately 5 hours. VHA policy requires that RCAs be completed within a maximum of 45 days from the date of the incident. The RCA debriefing was done by audio conference within the 45-day timeframe. However, misunderstandings occurred concerning changes in the RCA recommendations, and the signature agreement by leadership at one involved facility was not returned until 1 month following the debriefing, extending the process to a total of 75 days.

Suggested Improvement Action 2. We suggested that the VISN and Medical Center Directors require proper implementation of corrective actions in a timely manner by all medical facilities that will be affected by actions resulting from RCAs.

The VISN and Medical Center Directors agreed with the findings and suggestion and reported that agreed upon changes to the RCA recommendations and follow-up actions were not coordinated effectively and resulted in an inconsistent understanding across the organization. To address this issue, changes will be made to the document and agreed upon by all parties involved prior to obtaining concurrence signatures.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better Use of Funds by obtaining documented need for eyeglasses with special lenses.	$55,799

Appendix B

VISN 2 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2004

From: VISN 2 Director

Subject: **VA Medical Center Bath, New York**

To: Jacqueline L. Stumbris

1. I appreciate the opportunity to review the Office of Inspector General Combined Assessment Program draft report of the recent visit to the Bath VA Medical Center in March 2004. I have reviewed the comments and implementation plan submitted by the Medical Center Director and concur with his remarks.

2. Please extend my appreciation to the review team for their thorough evaluation and report of their visit to the Bath VA Medical Center.

/s/
WILLIAM F. FEELEY

Appendix C

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2004

From: Medical Center Director

Subject: **VA Medical Center Bath, New York**

To: Jacqueline L. Stumbris

1. I have reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the Bath VA Medical Center. I concur with the findings and am attaching action plans for each finding.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

/s/
DAVID P. WOOD

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.

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN and Medical Center Directors ensure that VISN and medical center contracting officials take action to: (a) document medical need to justify the procurement of special eyeglass lenses, (b) conduct database searches of EPLS prior to awarding the contract, (c) forward contracts, when appropriate, to the OA&MM for technical review prior to contract execution, (d) document justification to exercise option years, (e) verify appropriate licensure for contract CBOC employees, and (f) initiate background investigations for contractor personnel with access to VA computer systems and sensitive information prior to contract performance.

Concur **Target Completion Date:** Listed by item

The VISN Network Contracting Activity (NCA) will conduct a three-day face-to-face meeting in June 2004. Agenda items will include discussion of the findings of this OIG-CAP review and formulation of a network-wide contract checklist. In addition, a review of contracts will be conducted throughout VISN 2 to ensure that all contracts comply with FAR, VA Acquisition Regulations (VAAR), and other directives, policies, and requirements.

(a) document medical need to justify the procurement of special eyeglass lenses

Short-term Action Plan: The Contracting Officer will provide remedial COTR training regarding the scope of work contained in the contract and appropriate documentation of medical files. Remedial training can be written or verbal, but must be documented. Completion Date: August 1, 2004.

Long-term Action Plan: COTR's will audit medical files to ensure appropriate documentation is included and submit a written report to the Contracting Officer verifying action. Completion Date: On-going.

(b) conduct database searches of the Excluded Parties Listing System (EPLS) prior to awarding the contract

Short-term Action Plan: Database searches were conducted on EPLS for the two VISN contracts that lacked this review at the time of award. No records of ineligibility were found. Completed April 9, 2004.

The Business Review Checklist will be utilized by all Contracting Officers to audit appropriate documentation in contract files. A copy of each checklist will be forwarded to the Network Contract Manager (NCM) and used by the NCM during auditing of contract files. Completion Date: July 31, 2004.

Long-term Action Plan: The NCM or his/her designee shall complete audits of contract files on an annual basis. Completion Date: On-going.

(c) forward contracts, when appropriate, to the OA&MM for technical review prior to execution

Short-term Action Plan: Technical review of contracts exceeding $500,000 was needed. A technical review of the VISN contract mentioned in the report is not possible or practical since the contract has been in effect since 1999, is scheduled to expire in June, 2004, and clauses changed periodically. Other contracts were reviewed and will continue to be reviewed as prescribed.

Training will be conducted regarding Legal/Technical Review requirements at the face-to-face meeting planned for June 2004. Completion Date: August 1, 2004.

Long-term Action Plan: The NCM or his/her designee shall complete audits of contract files on an annual basis. Completion Date: On-going.

(d) document justification to exercise option years

Short-term Action Plan: Contracting Officers will audit contract files for presence of appropriate documentation. Past performance reports shall be obtained from the COTRs and included in the contract file by the Contracting Officer for use as documentation supporting exercising of option years. Completion Date: August 1, 2004.

Training will be conducted regarding documentation need in order to exercise options at the face-to-face meeting planned for June 2004. Completion Date: July 30, 2004.

Long-term Action Plan: A spreadsheet will be developed and used to track contract files containing option years. Contracting Officers will submit written requests to COTRs for past performance information and justify whatever action is appropriate in the contract file. Contract files will be audited to ensure documentation is included in the file. Completion Date: On-going.

(e) verify appropriate licensure for contract CBOC employees with access to VA computer systems and sensitive information

Short-term Action Plan: The Contracting Officer conducted a face-to-face meeting with the Contractor and COTR regarding credentialing requirements. Completed: April 15, 2004.

The Contracting Officer will provide remedial COTR training regarding the scope of work contained in the contract and appropriate documentation of contract personnel. Remedial training can be written or verbal, but must be documented. Completion Date: July 30, 2004.

Long-term Action Plan: COTRs will routinely audit contract personnel to ensure adherence to credentialing requirements and submit a written report to the Contracting Officer verifying action. Completion Date: On-going.

(f) initiate background investigations for contractor personnel prior to contract performance

Short-term Action Plan: The Contracting Officer initiated background investigations for two nurses providing primary/preventive care at the Wellsville CBOC and the eight physicians designated as the Medical Officer of the Day. Completed: Background investigation was initiated in April 2004 and will be completed by October 30, 2004 or sooner if OPM adjudicates the investigation.

Long-term Action Plan: In accordance with IL 90-01-6 entitled CONTRACTOR PERSONNEL SECURITY REQUIREMENTS, background investigations will be initiated with the Office of Security and Law Enforcement (07) for all contractor personnel requiring access to the VA's computer system. Said investigations will be initiated after contract award and prior to contractor performance. In addition, each contract requiring contractors' personnel to have access to the VA's computer system shall contain the appropriate language as outlined in the IL. The NCM or his/her designee will audit files to ensure compliance. Completion Date: On-going.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires FMS management to conduct annual inventories, implement GIP to control engineering supplies, reduce inventory levels, and report back any resultant savings.

Concur **Target Completion Date:** January 1, 2005

Implementation of GIP will begin with training on May 3, 2004, with implementation completed by January 1, 2005. We have ordered the necessary equipment to include printers and scanners. We will target high-use and high-activity inventory items and work to reduce inventory in those areas where feasible and perform annual inventory. As indicated in the summary findings, the exact amount of excess inventory could not be estimated. However, the VAMC plans to determine the amount of savings that result from reducing inventory levels and will report this savings to the OIG.

OIG Suggestions

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the Medical Center Director monitors the implementation and effectiveness of the peer review action plan.

Concur **Target Completion Date:** May 30, 2004

A special meeting was called on April 5, 2004, by the Chief of Staff with all members of the Peer Review Committee to discuss the OIG findings and recommendations. The Peer Review Committee then met on April 13, 2004 to review standards for care. The most recent review was sent off-station to the VA Medical Center Buffalo for review and recommendations. The President of the Medical Staff, Dr. Milena Lombardi, and Carroll Montalva from the OIG, have been in communication for guidance and suggestions on re-creating the peer review process at our facility. The Standards of Care will be set by local policies, national policies and the VHA "Clinical Practice Guidelines," as well as other nationally accepted principles of practice such as the American Academy of Family Physicians, American Academy of Physician Assistants, American Academy of Nurse Practitioners, and other organizations. The committee will ensure that each review will be screened by a peer and that the peer will be in attendance when the case is discussed.

Suggested Improvement Action 2. We suggest that the VISN and Medical Center Directors require proper implementation of corrective actions in a timely manner by all medical facilities that will be affected by actions resulting from RCAs.

Concur **Target Completion Date:** April 28, 2004

In the RCA referenced, the Medical Center leadership from impacted facilities as well as VISN Care Line leadership attended the final debriefing and concurred with the findings and recommendations. However, agreed upon changes to the recommendations and follow-up actions were not coordinated effectively and resulted in an inconsistent understanding across the organization. To address this issue, changes will be made to the document and agreed upon by all parties involved prior to obtaining concurrence signatures.

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Jacqueline L. Stumbris (781) 687-3143
Acknowledgments	Annette Acosta John Cintolo Jeanne Martin Patricia McGauley Carroll Montalva Amy Mosman Steven Rosenthal Joseph Vivolo

Appendix E

Report Distribution

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