Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

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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.
- 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.

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 June 6–10, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the William S. Middleton Memorial Veterans' Hospital (referred to as the hospital), Madison, WI. 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 98 employees. The hospital is under the jurisdiction of Veterans Integrated Service Network (VISN) 12.

Results of Review

This CAP review focused on 11 areas. As indicated below, there were no concerns identified in two of the areas. The remaining nine areas resulted in recommendations for improvement.

The hospital complied with selected standards in the following areas:

- Agent Cashier
- Service Contracts

Based on our review, the following organizational strength was identified:

- The Telecommunications Centralized Attendant located at the hospital saved VISN 12 $300,000 annually.

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

- Strengthen controls over prescription drugs.
- Strengthen controls over coding and billing of Medical Care Collections Fund (MCCF) accounts.
- Correct safety deficiencies.
- Improve accounts receivable follow-up and employee clearance procedures and correct Aging of Accounts Receivable Reports.
- Continue reducing excess supply stock levels.
- Improve timeliness of colorectal cancer (CRC) diagnosis and treatment and establish a Tumor Registry Program.
- Follow up with Government purchase card vendors and close outstanding purchase card-related purchase orders.

- Ensure that employees complete annual Cyber Security Awareness Training and terminate inactive information technology user accounts.
- Improve credentialing and privileging (C&P) processes and medication management reviews.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

VISN Director Comments

The VISN Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 19 for the full text of the Director's comments.) We will follow up on the implementation of planned improvement actions until they are completed.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Hospital Profile

Organization. Located in Madison, WI, the hospital provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based clinics located in Beaver Dam, Baraboo, and Janesville, WI; and Rockford and Freeport, IL. The hospital is part of VISN 12 (http://vaww.visn12.med.va.gov/) and serves a veteran population of about 235,000 in a primary service area that includes 15 counties in south-central Wisconsin and 5 counties in northeastern Illinois.

Photograph 1 – William S. Middleton Memorial Veterans' Hospital

Programs. The hospital provides tertiary medical, surgical, neurological, and mental health services. The hospital has 87 authorized hospital beds, is a national referral center for heart and lung transplantation, is host to a Geriatric Research Education Clinical Center, and operates several regional referral and treatment programs, including cardiac surgery, neurosurgery, and epilepsy. The hospital also has sharing agreements with the University of Wisconsin Hospital and Clinics, the University of Wisconsin Medical School, Dean Health System, and others.

Affiliations and Research. The hospital is affiliated with the University of Wisconsin Medical School and supports 87 medical student positions in 27 training programs. In fiscal year (FY) 2004, the hospital research program had 240 projects and a VA budget of $2.7 million. Important areas of research include geriatrics, Alzheimer's, hypertension, infectious disease diagnosis, swallowing disorders, orthopedic surgery, diabetes, kidney disease, colon, lung and prostate cancer, and pulmonary diseases.

Resources. In FY 2004, medical care expenditures totaled $165.3 million. The FY 2005 medical care budget is $169.3 million, 3.2 percent more than FY 2004 expenditures. FY 2004 staffing was 849 full-time employee equivalents (FTE), including 63 physician and 264 nursing FTE.

Workload. In FY 2004, the hospital treated 31,009 unique patients, a 1.7 percent increase from FY 2003. The inpatient workload totaled 3,541 discharges, and the average daily census was 68.6. The outpatient workload was 269,071 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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, 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 medical facilities use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. In performing the review, we inspected work areas, interviewed managers, employees, and patients, and reviewed clinical, financial, and administrative records. The review covered the following areas:

Accounts Receivable	Information Technology Security
Agent Cashier	Medical Care Collections Fund
Colorectal Cancer Management	Quality Management Program
Controls over Prescription Drugs	Service Contracts
Environment of Care	Supply Inventory Management
Government Purchase Cards	

We also followed up on five recommendations and suggestions included in our previous CAP review report (*Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital*, Madison, Wisconsin, Report No. 02-01159-145, dated August 5, 2002). All five of the following activities complied with selected standards:

Homemaker/Home Health Aide Program	Research Space Security
Informed Consent of Research Patients	Timekeeping for Part-Time Physicians
Performance Measures	

The review covered facility operations for FY 2003, FY 2004, and FY 2005 through June, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strengths

VISN 12 Telecommunications Centralized Attendant. The medical facilities of VISN 12 consolidated their telephone operator services at the hospital to reduce costs and enhance service. Through this effort, staffing levels were reduced more than 20 percent, hours of coverage were expanded to 24 hours/7 days a week for all VISN medical facilities, and quality of service was improved. Automated systems capture quality-related data to ensure compliance with VISN service goals and protocols. The VISN 12 Telecommunications Centralized Attendant is the first one of its kind in Veterans Health Administration (VHA) and is a model for telephone operators in a consolidated health care setting. Over 1.7 million calls were processed during the 12 months prior to our CAP review, with an average speed to answer of less than 14 seconds and an abandonment rate of less than 4 percent. These improvements have resulted in increased customer satisfaction and improved performance by operators. The total annual savings attributable to use of the Telecommunications Centralized Attendant for VISN 12 is $300,000.

Opportunities for Improvement

Controls over Prescription Drugs – Certain Controls Needed To Be Strengthened and Inspections Completed

Condition Needing Improvement. VHA and Drug Enforcement Administration policies intended to protect against loss and theft of prescription drugs differ based on the type of drugs involved. There are two broad categories of prescription drugs, controlled substances and non-controlled substances. Controlled substances are subdivided into five "schedules." Schedule I[1] and Schedule II substances require the most stringent controls. Our assessment of pharmacy controls, inspection procedures, dispensing practices, and security identified five deficiencies that needed to be addressed.

Inventory Management. Some physical inventories of prescription drugs were not completed. VHA policy requires that wall-to-wall physical inventories be conducted annually for both controlled and non-controlled substances located in Pharmacy Service and every 72 hours for all controlled substances.

Pharmacy Service staff did not conduct any 72-hour physical inventories of controlled substances between May 25 and June 6, 2005. This occurred because maintenance work that was being performed in the pharmacy area interfered with efficient pharmacy operations and staff decided to forgo physical inventories during the work. In addition, records of 72-hour physical inventories of controlled substances conducted just prior to May 25 revealed that eight expired drugs identified during the physical inventories were not removed from stock timely. For example, during a 72-hour physical inventory conducted on April 11, staff identified 500 doses of alprazolam 0.25mg that had expired. However, these expired drugs continued to be recorded in 72-hour physical inventory records through April 21.

Monthly Controlled Substances Inspection Procedures. Hospital staff assigned to conduct monthly controlled substances inspections needed to be better trained to ensure that they performed all of the inspection duties required of them by VHA policy. Based on observation of a controlled substances inspection and on reviews of inspection documentation, we found that inspectors did not:

- Note apparent discrepancies in balances between automated Veterans Health Information Systems and Technology Architecture (VistA) "Current Stock for Inpatient Pharmacy" reports and VA Forms 10-2320, *Schedule II, Schedule III Narcotics, and Alcoholics Register*. Inspectors did not note and comment on the

[1] The hospital did not use Schedule I substances. Schedule I substances are typically non-therapeutic and highly abuseable drugs, such as heroin and marijuana, that are rarely used in VA facilities and then only for research purposes.

discrepancies involving alprazolam referenced in the Inventory Management section, above.

- Reconcile 1 day's dispensing from Pharmacy Service to units with automated controlled substances dispensing devices. Surgical Service used an automated Pyxis® machine to store and dispense controlled substances. However, monthly controlled substances inspectors did not validate 1 day's dispensing from that machine as part of their monthly controlled substances inspections.

- Include controlled substances stored in a pharmacy cache in monthly controlled substances inspections. Pharmacy Service staff received an emergency pharmaceutical cache, which included controlled substances from the City of Madison, in June 2002. The cache contained 19 doses of a controlled substance. Monthly controlled substances inspections performed prior to April 2005 did not include verification of the contents of the cache.

- Include controlled substances maintained in Research Service in monthly controlled substances inspections. Controlled substances inspectors did not include Research Service controlled substances in their monthly inspections until April 2005.

Physician Orders and Patient Counseling for Controlled Substances. In a review of records for seven controlled substances administered or dispensed to patients, we found that controlled substances were issued to patient care units and clinics in accordance with VA policies. In addition, medical record documentation of controlled substances administered or dispensed to patients agreed with automated controlled substances accountability records. However, there were two examples where clinician practice needed improvement.

- Two physician orders for controlled substances were ambiguous in that they provided for a range of administration times, which violated hospital policy.

- One patient did not receive counseling after being prescribed a new controlled substance, which was contrary to VHA policy.

Controlled Substances in Research Service. VA policy requires that all controlled substances for use in research, whether animal or human, be ordered through Pharmacy Service. Investigators assigned to Research Service were in possession of 11 different controlled substances. Of those, five were obtained directly from the University of Wisconsin School of Medicine. Because VA Pharmacy Service staff had no record of dispensing those five controlled substances, we were unable to determine what amounts of these controlled substances should have been in the possession of investigators. However, the investigators did keep detailed dispensing records for controlled substances under their control, with one exception. One investigator was in possession of 1 cc of diluted buprenorphine for which there was no corresponding control document.

Controlled substances that are acquired from outside sources and that are outside VA's normal control systems are vulnerable to undetected diversion.

Controlled Substances Receiving Procedures. VHA policy requires that medical facilities establish written procedures for the ordering and receipt of controlled substances. The procedures …must indicate the individuals from Acquisition and Materiel Management Service and Pharmacy Service staff who have the designated authority to order, receive, post, and verify controlled substances orders…." Although the hospital's controlled substances accountable officer was appointed in writing, other staff, both Pharmacy Service and non-Pharmacy Service staff who participated in the receiving process for controlled substances, were not appointed in writing.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Hospital Director takes action to: (a) comply with policies governing physical inventories of controlled and non-controlled substances; (b) train monthly controlled substances inspectors to ensure that they perform all the duties required of them by VHA policies; (c) ensure that physician orders for controlled substances and patient counseling for newly prescribed controlled substances comply with hospital and VHA policies; (d) require that Research Service investigators obtain controlled substances through Pharmacy Service and follow VA accountability procedures; and (e) appoint, in writing, staff who participate in the receiving, posting, and verification processes for controlled substances.

The VISN Director agreed with the findings and recommendations. The hospital requires 72-hour inventories for both the inpatient and outpatient pharmacies and the Controlled Substance Inspectors verify each month that these audits are performed as required. The Controlled Substance Inspectors attend mandatory monthly training. This training is documented and inspectors are required to take an annual certification course. Compliance with the inspection directives and policies is monitored by the Chief of Staff office. A process action team was formed to ensure compliance with regulatory expectations and accreditation standards. The pharmacy patient education template will be revised to improve ease of use for counseling documentation in the medical record. Pharmacy staff will be educated on use of the template and the pharmacy manager will ensure use of the template by reviewing 20 new prescriptions per month for a period of three months. Research investigators were educated on procedures for ordering and handling controlled substances and remedial one-on-one education continues. The hospital memorandum for Accountability of Controlled Substances has been updated. Written appointments for the pharmacy staff are documented in letters dated March 22, 2005, and written appointments for non-pharmacy staff will be completed by August 5, 2005.

Medical Care Collections Fund – Collections Needed To Be Improved

Condition Needing Improvement. Hospital MCCF staff and contracted billing staff properly billed third party insurance carriers for care provided to VA patients on a fee basis. Public Law 105-33 authorizes VA to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the hospital collected $12.7 million from insurance carriers, which exceeded its goal of $12 million. MCCF collections could be increased by ensuring that clinicians adequately document care provided at the hospital, medical records coding staff correctly code medical records, and contracted billing staff correctly interpret medical records.

The hospital's May 9, 2005, "Reasons Not Billable Report," and covering the first quarter of FY 2005 showed 560 cases totaling $107,428 that were not billed to insurance. These cases were not billed because of insufficient documentation or because care was provided by a non-billable provider, for example, a resident physician. A random sample of 50 of these cases, totaling $6,603, identified 44 that could have been billed had documentation been accurate and complete or had preventable conditions not existed.

- In 13 cases, MCCF contracted billing staff did not issue bills totaling $1,989 because providers did not adequately document the care they had provided. This occurred because providers' progress notes were not present in medical records or did not include all of the information required by insurance carriers such as diagnoses, physician referrals, or current treatment orders.

- In 10 cases, contract billing staff did not issue bills totaling $801 because the medical care had been provided by non-billable providers (resident physicians) and the medical records contained no evidence of countersignatures by supervising attending physicians.

- In eight cases, contract billing staff did not issue bills totaling $664 because of confusion about the need for attending physician countersignatures on medical records. In six cases, contract billing staff did not issue bills because they misinterpreted automated medical records regarding the presence of required attending physicians' countersignatures. In two cases, contract billing staff did not issue bills because medical records coding staff failed to indicate in the automated medical records that attending physician signatures were, in fact, present.

- In seven cases, contract billing staff issued bills for the institutional component of care provided to patients but did not include the clinician component of that care. The unbilled components totaled $1,946.

- In four cases, contract billing staff did not issue bills totaling $434 for the care provided because medical record coding staff misidentified attending physicians as resident physicians.

- In one case, contract billing staff did not issue a bill of $228 for the care provided because the case was overlooked during conversion from older medical record coding and billing software to a newer version.

- In one case, contract billing staff did not issue a bill for $69 because coding staff had misidentified the care that was provided as fee basis rather than as VA.

The sample of 50 episodes of care showed that 44 (88 percent) could have been billed in the amount of $6,131; this is an average of $139 per episode. Based on the sample results, we estimated that the universe of 560 episodes of care during the first quarter of FY 2005 contained 493 (560 x 88 percent) that could have been billed. If projected to the entire fiscal year, there would be about 1,972 episodes of care (493 first quarter episodes x 4 quarters) totaling $274,108 (1,972 episodes x $139 per episode) that will not have been billed but could be. Based on the hospital's collection rate of 17.7 percent, we estimated that the hospital could have increased collections by $48,517 ($274,108 x 17.7 percent).

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Hospital Director takes action to: (a) ensure that clinicians adequately document medical care to satisfy insurance carriers' billing requirements; (b) ensure that coding staff correctly identify clinicians who provide medical care; (c) provide training to contract billing staff to ensure that they correctly interpret medical records; and (d) review the 44 cases of unbilled episodes of care cited above, obtain or correct the required documentation, and bill insurance carriers where appropriate.

The VISN Director agreed with the findings and recommendations. The hospital has stationed a coder in the outpatient primary care clinics for 4 hours per week to provide education to clinicians on documentation requirements and diagnosis and procedure coding. The hospital Compliance Officer collaborated with the Credentialing Office, Clinical Services, and Information Resource Management Service staff to ensure signatures and titles of clinicians providing care are accurately reflected in the Person Class File. Training for contract billing staff was completed by Patient Financial Service (PFS) staff in January 2005. The PFS Billing Supervisor performs a weekly monitor of their claims to ensure accuracy. Hospital Patient Administration Service and VISN PFS staff reviewed the 44 unbilled cases. PFS billed 21 of 44 cases.

Environment of Care – Safety Deficiencies Needed To Be Corrected

Condition Needing Improvement. Hospital managers maintained a clean and sanitary environment for patients. We inspected patient rooms and restrooms on four inpatient units and toured the hospital perimeter. Two conditions required management attention.

Security of Storage Areas. The biohazardous waste and clean patient care supply storage areas were unlocked on three of the four units inspected. The biohazardous waste storage

area is a collection site for regulated medical waste, full sharps containers with dirty needles and syringes, and contaminated sharp instruments awaiting pick up for sterilization. The clean patient care supply storage rooms where sharps such as needles, hemostats, tweezers, and scissors are stocked; and sterile supplies are stored for patient care use needed to be protected from tampering and diversion. These areas should not be accessible to the public. We recommended that these areas be locked to ensure patient safety.

Security of the Recycling and Waste Handling Dock. During a perimeter tour of the hospital, we observed red biohazardous waste bags in a cart and full sharps containers in the dock area. The loading door to the dock was open, and two doors leading to the area were unlocked. We recommended that managers take immediate action to secure the area to prevent unauthorized access.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Hospital Director takes action to ensure (a) biohazardous waste and clean patient care supply storage areas are locked and (b) biohazardous waste is secured at the recycling and waste handling dock.

The VISN Director agreed with the findings and recommendations. A hospital-wide assessment of spaces where biohazardous waste and clean patient care supplies are stored was conducted. The 21 rooms that are not currently secured will be equipped with proper security mechanisms. The Environment Support Service Standard Operating Procedures and Police and Security's practice is to keep the door of the recycling and waste handling dock closed and secured when not occupied. The Hospital's Housekeeping Officer will monitor compliance with this requirement through regular inspection.

Accounts Receivable – Follow-Up and Clearance Procedures Needed To Be Improved and the Aging of Accounts Receivable Report Corrected

Condition Needing Improvement. Fiscal Service staff established accounts receivable in accordance with VA policy and used appropriate follow-up and collection procedures for vendor accounts receivable. However, there were three areas where Fiscal Service staff needed to improve collection and documentation of accounts receivable for employees and former employees.

Follow-Up of Delinquent Employee Accounts Receivable. VA policy requires prompt and aggressive follow-up of accounts receivable and establishes a uniform collection procedure. The policy requires Fiscal Service staff to send an initial collection letter within 30 days of the establishment of a receivable and second and third letters at 30-day intervals.

As of May 31, 2005, there were 98 employee-related accounts receivable totaling $41,823 (51 accounts receivable for current employees totaling $23,015 and 47 for former employees totaling $18,808). Seventy-seven, totaling $31,107, of the 98 employee-related accounts receivable were over 90 days old. We reviewed a judgment sample of 20 of these totaling $23,580. Follow-up action was not timely. For example:

- Action on a waiver request was not timely. An employee, who owed $3,047 on two accounts receivable, sent a letter on June 13, 2003, disputing the debts and requesting a waiver. However, Fiscal Service staff did not act on the waiver request and sent the employee a second collection letter on September 28, 2004. The employee responded on October 6, 2004, by again requesting a waiver. As of June 7, 2005, Fiscal Service staff still had not acted on the employee's waiver request.

- Follow-up collection action on two accounts receivable, totaling $610 owed by one employee, was not timely. Fiscal Service staff sent an initial collection letter on November 8, 2004, but did not send a second follow-up letter until April 1, 2005.

- Collection action on one account receivable for $3,085 for a former employee was not timely. The employee resigned on October 15, 2001, prior to the expiration of the employee's contract; therefore, the employee was not entitled to special pay received during employment. Although Fiscal Service staff properly held funds from the employee's last salary payment to cover the special pay overpayment, the funds were erroneously released to the former employee on July 18, 2002. Fiscal Service discovered the error on December 17, 2002, and established an account receivable. However, they did not send an initial collection letter until April 1, 2005.

Fiscal Service staff contributed to untimely follow-up of delinquent accounts receivable by preparing collection letters manually rather than allowing an automated accounting system to generate them automatically. According to Fiscal Service staff, they did this because they did not have ready access to a computer printer, a condition which they agreed to correct.

Clearance Procedures. VA policy requires that Human Resources Management Service staff notify Fiscal Service staff when employees terminate their employment. Twelve of the 20 sampled accounts receivable were for former employees. Three of those former employees cleared station without their debts, which totaled $1,318, being collected. According to the Assistant Financial Manager, this occurred because the payroll section of Fiscal Service was understaffed.

Accuracy of Aging of Accounts Receivable Report. Dates accounts receivable were established as shown on the Aging of Accounts Receivable Report did not match dates shown in individual accounts receivable profiles for 6 of the 20 sampled accounts receivable. This occurred because Fiscal Service staff, in an effort to establish audit trails, inadvertently changed account establishment dates in the Aging of Accounts

Receivable Report when they reviewed accounts or took follow-up action, which created misleading information about the status of accounts receivable.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Hospital Director takes action to: (a) aggressively pursue delinquent employee accounts receivable, (b) ensure that clearance procedures are followed when employees terminate their employment, and (c) ensure that Aging of Accounts Receivable Reports are accurate.

The VISN Director agreed with the findings and recommendations. Weekly meetings between the accounting and payroll offices will be held to review the list of employee debts. A spreadsheet will be maintained by the accounting office to document all follow-up actions and resolutions. The employee clearance process will be reviewed with Finance Office staff at their August 9, 2005, staff meeting. The Finance Office's previous practice to update the last action date in order to establish an audit trail was stopped in 2003; however, bills that were previously updated cannot now be reversed to the correct date. These bills are the priority for resolution by the end of December 2005. This process will also be reviewed with Finance Office staff at their August 9, 2005, staff meeting.

Supply Inventory Management – Stock levels Needed To Be Reduced

Condition Needing Improvement. VHA policy requires that medical facilities establish medical, janitorial, engineering, and prosthetics supply inventory levels that do not exceed 30 days of stock on hand. Medical facilities are required to use the Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to analyze usage patterns, establish normal sock levels, determine optimum order quantities, and help conduct physical inventories. Use of GIP and PIP should result in reduced supply inventory stock levels and corresponding savings of medical care funds.

The hospital had fully implemented use of both GIP and PIP, and staff used these systems to control and manage supplies. Acquisition and Materiel Management Service and Prosthetics Service staff conducted required wall-to-wall physical inventories, and the accuracy of inventory data contained in GIP and PIP was good. However, hospital staff needed to reduce supply inventory stock levels. As of June 8, 2005, GIP data showed supply stock levels in excess of 30 days totaling $929,687. PIP data showed supply stock levels in excess of 30 days totaling $6,126. Staff responsible for managing these supply inventories were aware that stock levels needed to be reduced and had initiated coordinated action with VISN 12 staff to reduce supply inventory stock levels.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Hospital Director continues efforts to reduce supply inventory stock levels to 30 days of stock on hand.

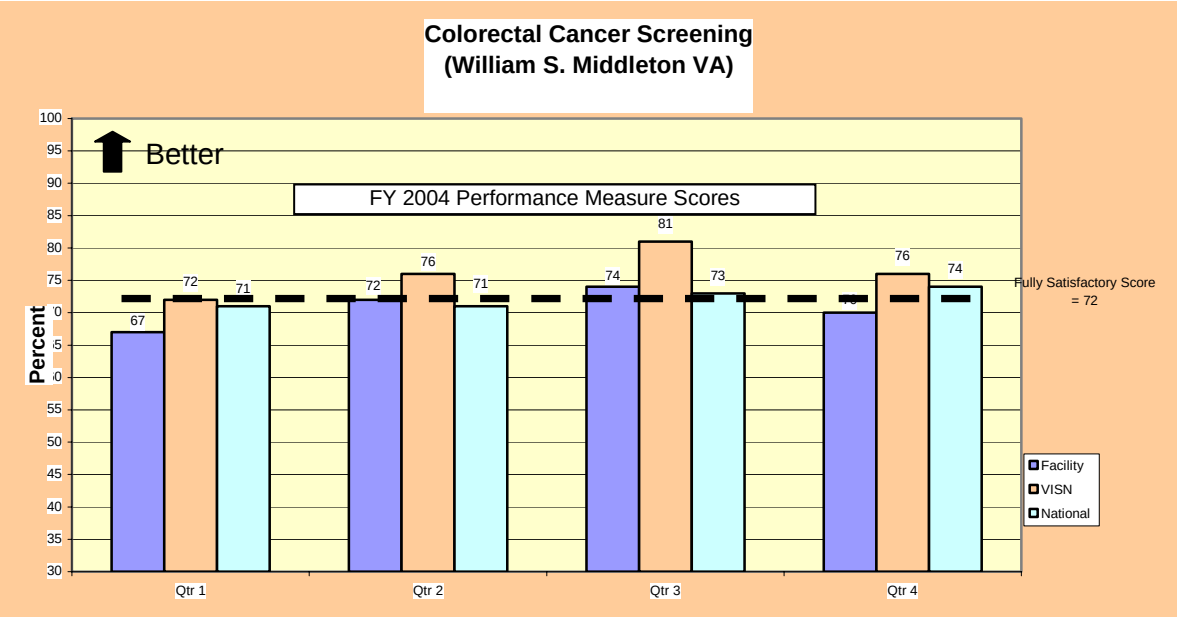
The VISN Director agreed with the findings and recommendations. The hospital's SPD and Warehouse inventories consistently average turn-over rates of 12 turns or greater, according to the monthly Stock Status Report. This is consistent with VHA policy to use GIP for specific programs and to achieve a 30-day stock on hand for the entire inventory. Some inventory items will be greater than a 30-day supply and some less. This is what we strive to attain.

CRC Management – Hospital Needed to Improve Timeliness of Diagnosis and Treatment and Establish Tumor Registry Program

Condition Needing Improvement. Clinicians needed to improve the timeliness of CRC diagnosis and treatment and establish a Tumor Registry Program. The hospital appropriately screened patients for CRC, promptly informed patients of diagnoses, and developed coordinated interdisciplinary treatment plans. The hospital had an average performance measure score of 71 percent for CRC screening in FY 2004.

Criteria. The VHA CRC screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a random sample of 10 patients who were diagnosed with CRC during FY 2003 (8 patients) and FY 2004 (2 patients). For the purpose of this review and because hospital policy did not define reasonable timeframes, we used 90 days from initial concern to diagnosis and 45 days from diagnosis to earliest treatment as reasonable timeframes.

Findings.



Patients appropriately screened	Patients diagnosed within 90 days	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received initial treatment within 45 days
10	8	10	10	8

During FYs 2003-2004 (the focus of our review), the hospital did not have a Tumor Registry Program.

Cause. Diagnostic gastrointestinal (commonly referred to as GI) procedures were not performed quickly as intended, because of increased workload. Our review of workload from FY 2000–2004 confirmed a significant increase in procedures from 2,371 to 3,355 (41 percent). The hospital had a backlog of 1,200 flexible sigmoidoscopy procedures during 2003. The GI Clinic was short one FTE in FY 2004, and this was filled at the time of our inspection. Hospital mangers told us they hired two Nurse Practitioners, one Gastroenterologist, and implemented additional half-day clinics in GI at Madison and Rockford. These actions reduced the backlog of flexible sigmoidoscopies, allowing completion of the procedures within 30 days.

Hospital managers told us that in March 2005 the hospital initiated a contract with a private company to implement their Tumor Registry Program. The contracting company completed FY 2003 data collection, and the projected completion date for FY 2004 data collection is August 2005.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director takes action to (a) improve timeliness of CRC diagnosis and treatment and (b) establish a Tumor Registry Program.

The VISN Director agreed with the findings and recommendations. To improve timeliness of CRC screening, the hospital has developed a protocol to direct low risk individuals to flexible sigmoidoscopy every three years with an occult blood series yearly. A new weekly colonoscopy clinic has been added. A new pathology process has been developed to ensure prompt response, patient notification and follow up on any positive finding. In March 2005, the hospital initiated a Tumor Registry contract with Certicode. The plan is to continue this contract.

Government Purchase Cards – Follow-Up Was Needed on Outstanding Purchase Orders from Prior Fiscal Years

Condition Needing Improvement. As of June 7, 2005, the hospital had 75 government purchase cardholders, 39 approving officials, and 170 purchase card accounts that included 8 purchasing agents and 2 approving officials at the Great Lakes Acquisition Center (GLAC). For FY 2005 through April, cardholders executed 12,433 purchase card transactions totaling $8.5 million. Cardholders and approving officials performed

reconciliations and approvals on time, and program controls were adequate. The coordinator reviewed transactions every other day, and sent e-mails to cardholders and approving officials to notify them of unreconciled and unapproved transactions. However, there was one area that needed to be improved.

Reports generated by the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system for FYs 2002 through 2004, showed there were 88 outstanding purchase card-related purchase orders with net balances totaling $82,600 ($92,300 positive or zero balances – $9,700 negative balances). One cardholder, a GLAC employee, was responsible for 20 of these totaling $51,400 ($59,900 positive or zero balances – $8,500 negative balances). Outstanding purchase orders impact fund control point balances, the ability to obtain credits from vendors, and the ability to timely dispute orders with vendors. For example:

- A vendor had not issued a credit of $6,792 on a purchase order dated September 2002.
- As of June 8, 2005, a vendor had not charged a cardholder's account even though all items from a $38,099 purchase order were received on December 14, 2004.
- A purchase order for $1,154 was outstanding because a vendor submitted four partial charges that did not match the dollar amounts of partial shipments and because the cardholder reconciled the transactions anyway.
- A purchase order with a zero balance was outstanding because the cardholder's reconciliation occurred after the approving official's approval. It appeared the cardholder attempted to edit a previously approved reconciliation without deleting the prior approval.

The purchase order balances existed because cardholders were not adequately and timely following up with vendors to resolve issues necessary to close outstanding purchase orders.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Hospital Director and the GLAC Chief Logistics Officer take action to require that cardholders follow up with vendors and resolve issues necessary to close outstanding purchase card-related purchase orders.

The VISN Director agreed with the findings and recommendations. For orders over 90 days, the Agency or Organization Program Coordinator will email the approving official and fund control point clerk/official requiring follow up action on each of the orders with action expected within 2 weeks. If follow up requests are ignored a second request email will be generated and the Hospital Director and the GLAC Chief Logistics Officer will be copied.

Information Technology Security – Certain Security Controls Should Be Improved

Condition Needing Improvement. Information technology (IT) security controls were adequate in the areas of risk assessment, virus protection, backup and recovery of essential data, and password protection. Appropriate background investigations had been requested for staff assigned to key positions. At the time of our review, the Chief Information Officer and Information Security Officer (ISO) were finalizing the hospital's certification and accreditation documentation. However, there were three areas where management could improve IT security.

Security Awareness Training. VA policy requires that all VA employees who have access to automated information systems complete Cyber Security Awareness training every year. During FY 2004, 618 hospital employees (43 percent) did not complete the required training. In FY 2005 through June 8, 938 employees (66 percent) had not completed the training.

Inactive Computer Accounts. VHA policy requires that access by users to VHA automated information systems be reviewed at least every 90 days for continued need for access. This policy also requires that users who have not accessed automated information systems for 90 days should have their access terminated. As of May 26, there were 96 training accounts and 185 user accounts that had not been used in over 90 days; these should have been deleted or de-activated. These accounts existed because their last use pre-dated implementation of software that automatically de-activates inactive accounts after 90 days.

VistA Imaging System Security Plan. Hospital staff did not include site-specific information in its VistA Imaging System security plan submitted for certification purposes to VHA VistA Imaging System program officials. The VistA Imaging System is an automated system for the electronic transmission between VA medical facilities of x-rays, computerized axial tomography scans, and other diagnostic patient images. A VistA Imaging System security plan follows a model plan developed by VHA program staff but is designed to allow hospital staff to incorporate details that are specific to the local site. The hospital ISO did not include site-specific information in its security plan submission because, according to the ISO, program officials had not provided guidance on development of site-specific security details.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Hospital Director takes action to: (a) establish controls to ensure that all hospital employees complete Cyber Security Awareness training annually, (b) terminate or de-activate training and user accounts that are no longer needed, and (c) submit site-specific information to the VHA VistA Imaging Program Office.

The VISN Director agreed with the findings and recommendations. A list of staff that have not completed Cyber Security Awareness training will be distributed to service chiefs for scheduling and follow-up. Weekly reminders will be sent to service chiefs and compliance reports distributed to service chiefs and Director's office. Ninety-six training and 186 use accounts not used in 90 days or deactivated existed because they pre-dated implementation of software that automatically de-activates accounts after 90 days. Manual extraction and deletion of these accounts will be completed. Certification and accreditation was recently completed at this hospital. Direction will be taken from VA Central Office.

Quality Management Program – C&P Processes and Medication Management Reviews Needed Improvement

Condition Needing Improvement. The QM Program was effective and senior managers were supportive of performance improvement initiatives. However, two areas needed improvement.

C&P Process. VHA directives require that clinically active staff maintain current cardiopulmonary resuscitation (CPR) certification. Four of five C&P files of licensed independent practitioners did not show evidence of CPR certification. The credentialing staff relied on the affiliated university medical center staff to maintain this documentation and ensure that it is current. Practitioners should present proof of this training at the time of initial privileging, and subsequent re-privileging documentation should reflect that the practitioners' CPR certifications remain current. This documentation should be maintained at the hospital.

VHA directives require that practitioner-specific QM data be reviewed during the process to renew privileges to practice medicine within the hospital. Service chiefs did not consistently document their accomplishment of this review, nor was there evidence of such a review included in the minutes of the Clinical Executive Board when practitioners were approved for re-privileging. Consideration of QM data is an important factor when determining competence at the time of re-privileging.

Medication Management Reviews. Managers collected and reviewed medication management data and made recommendations for improvement. However, specific improvement actions were not documented, and there was no follow-up to measure the effectiveness of any actions taken. Managers needed to develop methodologies to ensure recommended actions result in desired improvement.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Hospital Director requires that: (a) all licensed independent practitioners have current CPR certifications, (b) this information is available in their respective C&P hospital files, (c) QM data is considered and documented in the re-privileging process,

and (d) recommended improvement actions are specific and followed up to measure effectiveness.

The VISN Director agreed with the findings and recommendations. The Medical Staff will determine which attending staff need Basic Life Support and Advanced Cardiac Life Support. This will be written in the Cardiopulmonary Resuscitation Memo and the proof of certification will be included in provider files at the time of recertification. Medication use data will be aggregated and included in the provider files for consideration at the time of reprivileging. Medication management review has been added to the Patient Medication Safety and Utilization committee as a standing item on the monthly agenda. The agenda will include discussion and review of improvement actions and measures of effectiveness as a follow-up to the medication management reviews.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 10, 2005

From: VISN 12 Director

Subject: **William S. Middleton Memorial Veterans Hospital Madison, Wisconsin**

To: Director, Management Review Service (10B5)

1. Please find attached the William S. Middleton Memorial Veterans Hospital response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) Review conducted June 6-10, 2005.

2. I concur with the facility Director's comments, action plans and time frames.

3. Thank you for the thoroughness of your review and the professional conduct by your inspectors.

(original signed by:)

Renee Oshinski

Acting Network Director

VISN 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 Director ensure that the Hospital Director takes action to:

(a) comply with policies governing physical inventories of controlled and non-controlled substances;

Concur **Target Completion Date:** 6/6/05

The Madison VA requires 72 hour inventories for both the inpatient and outpatient Pharmacies. The Controlled Substance Inspectors verify each month that these audits are performed as required. During the dates between May 25th and June 6th, 2005, the inpatient pharmacy audits did not occur. A Pharmacy Tech made an independent decision not to perform the audit due in part to the ongoing construction in that area. The employee received verbal counseling on June 6th, 2005 by the Chief of Pharmacy and further administrative action may follow. The Pharmacy Supervisor or Manager ensures completion by signing the inventory. This process is reviewed during inspections by members of the Controlled Substance Inspection Team.

(b) train monthly controlled substances inspectors to ensure that they perform all the duties required of them by VHA policies;

Concur **Target Completion Date:** 8/3/05

The Controlled Substance Inspectors attend mandated monthly training. This training is documented in TEMPO and inspectors are required to take an annual certification course.

At the August 3, 2005 inspector training meeting, inspectors were educated that any outdated controlled substances found during an inspection be documented as a discrepancy and immediately removed from the inventory. They were also educated to reconcile one day's dispensing to automated controlled substance dispensing devices.

The May 2005 mandatory meeting included training on the inspection of controlled substances stored in the pharmacy cache and to include controlled substances maintained in Research Service in the monthly inspections.

In addition, all these areas are now included on the audit checklist. Compliance with the inspection directives and policies is monitored by the Chief of Staff Office.

(c) ensure that physician orders for controlled substances and patient counseling for newly prescribed controlled substances comply with hospital and VHA policies;

Concur **Target Completion Date:** 12/31/05

During our mock JCAHO survey, May 2005, the surveyor noted non-compliance with range orders, particularly for pain medications including controlled substances. As a result, a process action team was formed to ensure compliance with regulatory expectations and accreditation standards. During the OIG inspection, the Inspector was informed by the Chief, Pharmacy Service of the range order issue and our process action team approach to remedy deficiencies. This team began its work in July 2005 and has developed an action plan with implementation expected by October 1, 2005.

In respect to the identified issue of patient counseling for newly prescribed medications, it is hospital and pharmacy policy that patients receive counseling when medications are first issued. If the patient receives the same controlled substances month-to-month, even though a new prescription is required, we do not require counseling documentation. The pharmacy patient education template will be revised to improve ease of use for counseling documentation in the medical record. Pharmacy staff will be educated on the use of this template. The pharmacy manager will ensure use of the template by reviewing 20 new prescriptions for controlled substances per month for a period of three months. This action will be completed by 12/31/05.

(d) require that Research Service investigators obtain controlled substances through Pharmacy Service and follow VA accountability procedures;

Concur **Target Completion Date:** 8/3/05

Research investigators were educated on procedures for ordering and handling controlled substances on April 26th, 2005 and remedial one-on-one education continues to date. The hospital memorandum for Accountability for Controlled Substances (11-05-13) has been updated and now requires the Controlled Substance Inspector to remove and deliver to Pharmacy, any controlled substance that does not have the VA controlled substance record. The Madison VA Pharmacy does not have a DEA Schedule I registration. According to above mentioned policy dated April 21st, 2005, Schedule I controlled substances are to be obtained from an outside source and delivered by the investigator to pharmacy for appropriate handling and to ensure compliance with VA accountability procedures.

and (e) appoint, in writing, staff who participate in the receiving, posting, and verification processes for controlled substances.

Concur **Target Completion Date:** 8/5/05

The OIG Inspector requested copies of written appointments for Pharmacy staff participating in receiving, posting, and verification processes for controlled substances. These appointment letters dated March 22nd, 2005 were faxed to the Inspector the week of July 18th, 2005 as requested. Written appointments for the non-pharmacy staff will be completed by August 5th, 2005.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Hospital Director takes action to:

(a) ensure that clinicians adequately document medical care to satisfy insurance carriers' billing requirements;

Concur **Target Completion Date:** 7/14/05

To ensure adequate documentation for billing, the facility has stationed a coder in the outpatient primary care clinics for four hours per week. The coder provides education to clinicians on documentation requirements as well as diagnosis and procedure coding. The RNB report will continue to be monitored by the VISN 12 Patient Financial Service (PFS) Billing Supervisor for the origin of errors and corrective actions taken where needed.

(b) ensure that coding staff correctly identify clinicians who provide medical care;

Concur **Target Completion Date:** 7/20/05

The faculty Compliance Officer collaborated with the Credentialing Office, Clinical Services and IRMS staff to ensure signatures and titles of clinicians providing care are accurately reflected in the Person Class File. The PFS Billing Supervisor will monitor bills for identification errors and will notify the Compliance Officer to implement corrections.

(c) provide training to contract billing staff to ensure that they correctly interpret medical records;

Concur **Target Completion Date:** Completed

The RNB report examined by the OIG inspectors covered the first quarter of FY05 (Oct-Dec. 2004). Training for contract billing staff was completed by PFS staff in January 2005. The PFS Billing Supervisor performs a weekly monitor of their claims to ensure accuracy. When errors are identified the bill is returned to the biller for correction. The error rate for the contract is stipulated to be no more than 5% and continues to be below that level.

and (d) review the 44 cases of unbilled episodes of care cited above, obtain or correct the required documentation, and bill insurance carriers where appropriate.

Concur **Target Completion Date:** 6/10/05

Facility PAS and VISN PFS staff reviewed the 44 unbilled cases in the amount of $6,131. Upon the receipt of the required documentation and/or correct coding information, PFS billed 21 of the 44 cases. This was completed before the OIG CAP Review Team left the facility on June 10, 2005. To ensure continued compliance, the PFS Billing Supervisor conducts a monthly audit of the RNB report to ensure that billable episodes are not missed. The Billing Supervisor also performs weekly reviews of paper claims to ensure claim accuracy. Any errors are returned to billing or coding staff for correction. Formal billing accuracy audits are conducted quarterly for each biller by the Billing Supervisor. Performance accuracy is expected to be 95% or higher.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Hospital Director takes action to ensure:

(a) biohazardous waste and clean patient care supply storage areas are locked;

Concur **Target Completion Date:** 1/31/06

Currently, the biohazardous waste and clean patient care supply storage areas are often in unlocked rooms. A facility-wide assessment of spaces where these materials are held was conducted on August 1, 2005. The 21 rooms that are not currently secured will be equipped with proper security mechanisms. Purchase and installation of these required locks for compliance will be implemented through the FY06 NRM program.

and (b) biohazardous waste is secured at the recycling and waste handling dock.

Concur **Target Completion Date:** 9/1/05

For security of the recycling and waste handling dock, the Environment Support Service (ESS) Standard Operating Procedures (SOP) and Police & Security's practice is to keep this door closed and secured when not occupied. However, the loading door of the dock was found unsecured during the perimeter tour by the OIG team. The door was secured prior to the team's departure on the same shift of this occurrence. The Hospital Housekeeping Officer will monitor compliance with the requirement that this area be secure at all times through regular inspection.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Hospital Director takes action to:

(a) aggressively pursue delinquent employee accounts receivable;

Concur **Target Completion Date:** 12/30/05

The final version of the VISN 12 Standard Operating Procedures (SOP) resolving outstanding employee accounts receivable will be completed by August 31, 2005. Weekly meetings between the accounting and the payroll offices will be held to review the list of employee debts. A spreadsheet will be maintained by the accounting office to document all follow-up actions and resolutions. Overtime will be granted to work on delinquent employee bills. The preparation of collection letters is no longer done manually. The system is automatically generating the letters, and the accounting office is mailing them daily.

(b) ensure that clearance procedures are followed when employees terminate their employment;

Concur **Target Completion Date:** 8/9/05

Clearance forms were updated in 2003 to include the Finance Office as one of the stops. Clearance procedures were also updated to include a review of the Employee Bill list. If a bill exists, the employee is advised of their indebtedness to the federal government. Payroll is notified and the employee's final check is not released until the bill is satisfied. Old bills for current employees prior to the new clearance form will take first priority in establishing payroll deductions. This process will be reviewed with Finance Office staff at their August 9, 2005 staff meeting.

and (c) ensure that Aging of Accounts Receivable Reports are accurate.

Concur **Target Completion Date:** 12/30/05

The Finance Office practice to update the last action date used to establish an audit trail was stopped 2003. Bills that were updated cannot be reversed to the correct date. These bills are the priority for resolution by the end of December 2005. This process will be reviewed with Finance Office staff at their August 9, 2005 staff meeting.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Hospital Director continues efforts to reduce supply inventory stock levels to 30 days of stock on hand.

Concur **Target Completion Date:** Ongoing

We concur that there are inventory items in excess of 30 days stock on hand that could be reduced. However, we believe it is important to note that our SPD and Warehouse inventories consistently average turn-over rates of 12 turns or greater, as reported in our monthly Stock Status Reports. The "Days of Stock On Hand" (DSOH) report that was requested by OIG only accounted for specific items that were greater than 30 day supply and did not account for the total days of stock on hand for an inventory point. VHA Handbook 1761.2 mandates the use of GIP for specific programs and also refers to a 30 day stock on hand (which equates to a turn-over rate of 12) for the entire inventory. Some inventory items will be greater than a 30 day supply and some less. This average is what is intended by the VHA Handbook 1761.2 as it relates to each GIP inventory point and is what we strive to attain.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director takes action to:

(a) improve timeliness of CRC diagnosis and treatment;

Concur **Target Completion Date:** 12/31/05

To improve the timeliness of CRC screening the organization has developed a protocol to direct low risk individuals to flexible sigmoidoscopy every three years with an occult blood series yearly. This per the American Gastroenterological Association (AGA) and VA policy recommendations. Positive exams will then be screened by colonoscopy. In addition a new colonoscopy clinic per week has been added to reduce wait time. This will allow more prompt screening and the ability to perform colonoscopy in the positive finding patients in a more timely manner. Facility performance on the colon cancer screening measure for the first three quarters in FY05 is above the exceptional level.

A new pathology process has been developed to ensure prompt response, patient notification, and follow up on any positive finding. This includes automated computer notification of pathology results being available, review by two people of results, documentation of patient notification and a response plan on all GI pathology. This action is completed.

and (b) establish a Tumor Registry Program.

Concur **Target Completion Date:** Completed

During the past year the Madison VA has worked with the VA Central Office to capture data for the Tumor Registry for the years 2001-2003. This was completed in April 2004.

In March 2005, the Madison VA initiated a Tumor Registry contract with Certicode for the 2004 and 2005 cancer registry cases. By August 15, 2005 Certicode will complete the 2004 registry cases and begin working on the 2005 cases. The plan is to continue this contract.

Weekly updates of cases added into the registry are sent to the VA Central Office as requested.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Hospital Director and the GLAC Chief Logistics Officer take action to require that cardholders follow up with vendors and resolve issues necessary to close outstanding purchase card-related purchase orders.

Concur **Target Completion Date:** 9/30/05

The Agency or Organization Program Coordinator (AOPC) will run the "Status of Orders open greater than 90 days Report" monthly. For orders over 90 days, the AOPC will email the Approving Official and Fund Control Point Clerk/Official requiring follow up action on each of the orders with action expected within 2 weeks. A spreadsheet per cardholder will be maintained on all orders greater than 90 days. All documentation pertinent to the orders will be kept in the employee files. If follow up requests are ignored a second request email will be generated and the Hospital Director and the GLAC Chief Logistics Officer will be copied.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Hospital Director takes action to:

(a) establish controls to ensure that all hospital employees complete Cyber Security Awareness training annually;

Concur **Target Completion Date:** 9/30/05

Lists of staff having not completed Cyber Security Awareness training will be distributed to Service Chiefs for scheduling and follow-up. Additional computer classroom time will be made available to support users. Weekly reminders will be sent to Service Chiefs and compliance reports distributed to Service Chiefs and Director's Office.

(b) terminate or de-activate training and user accounts that are no longer needed;

Concur **Target Completion Date:** 9/30/05

Accounts are deactivated appropriately and timely through the established clearing process. At the time of the OIG CAP review, 96 training and 186 user accounts not used in 90 days or de-activated, existed because they pre-dated implementation of software that automatically de-actives inactive accounts after 90 days. Manual extraction and deletion of accounts remaining inactive prior to this time period (2002) will be completed by the target date.

and (c) submit site-specific information to the VHA VistA Imaging Program Office.

Concur **Target Completion Date:** Completed

Certification and Accreditation was recently completed at this facility. That process is controlled and coordinated through VA Central Office and VISN ISOs. VistA Imaging was not separated from the VistA System itself. Vista Imaging implementation and development is also coordinated centrally and is standardized across the VHA system. VistA Imaging is also considered a medical device and falls under the additional guidelines of the FDA. Direction will be taken from VA Central Office.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) all licensed independent practitioners have current CPR certifications, and (b) this information is available in their respective C&P hospital files;

Concur **Target Completion Date:** 9/30/05

At the August 2005 Clinical Executive Board, the Medical Staff will determine which attending staff will need BLS and ACLS. This will be written in the Cardiopulmonary Resuscitation Memo and the proof of certification will be included in provider files at the time of recertification.

(c) QM data is considered and documented in the re-privileging process;

Concur **Target Completion Date:** 9/30/05

This recommendation is related to the single issue of the absence of medication use data in the provider reprivileging files. High volume, problem prone, and high risk medications will be periodically reviewed with provider names attached. That data will be aggregated and included in the provider files for consideration at the time of reprivileging.

and (d) recommended improvement actions are specific and followed up to measure effectiveness.

Concur **Target Completion Date:** 9/19/05

In May 2005, medication management review was added to the Patient Medication Safety and Utilization Committee (PMSU) as a standing item on the monthly agenda. PMSU is a subcommittee of the Pharmacy and Therapeutics Committee. The agenda will include discussion and review of improvement actions and measures of effectiveness as a follow-up to the medication management reviews.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Preventing lost opportunities for billing for care provided in the hospital will increase collections from insurance carriers.	$48,517
5	Continuing to excess excessive supply inventory stock will allow better use of funds.	$929,687
	Total	$978,204

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	John Brooks Donald Bunce Paula Chapman Larry Chinn Mary Ann Fitzgerald William Gerow Kevin Gibbons Theresa Golson Wachita Haywood Dana Martin Jennifer Reed Annette Robinson Leslie Rogers William Wells

Appendix D

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