Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Coatesville, Pennsylvania

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VA Office of Inspector General
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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.
- 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 May 16–20, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Coatesville, PA, which is part of Veterans Integrated Service Network (VISN) 4. 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 186 employees.

Results of Review

This CAP review focused on 11 areas. The medical center complied with selected standards in the following four areas:

- Colorectal Cancer Management
- Contracting
- Environment of Care
- Pressure Ulcer Management

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

- Adhere to Veterans Health Administration (VHA) policy and Drug Enforcement Administration (DEA) regulations governing prescription drugs.
- Improve Medical Care Collections Fund (MCCF) billing, medical record documentation, and medical record coding.
- Ensure adequate segregation of duties and reduce the cash advance for the Agent Cashier.
- Follow-up on Department of Defense (DoD) accounts receivable.
- Comply with VA policy that prohibits splitting Government purchase card transactions.
- Submit Veterans Health Information Systems and Technology Architecture (VistA) security information to VHA program officials.
- Improve the root cause analyses (RCA) process.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Walter Pack, CAP Review Coordinator, Chicago Audit Operations Division.

VISN 4 and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. See Appendixes A and B, pages 17–27, for the full text of the Directors' comments. We will follow up on reported implementation actions to ensure they have been completed.

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

Introduction

Facility Profile

Organization. Located in Coatesville, PA, the medical center is a specialty referral, transitional care, and neuropsychiatric facility. Primary care and mental health services are provided at three community-based outpatient clinics (CBOCs) located in Philadelphia, Springfield, and Spring City, PA. The medical center is part of VISN 4's Eastern Market and serves a veteran population of about 579,000 that includes 15 counties in Pennsylvania, Delaware, and New Jersey.

Programs. The medical center has 472 operating beds including a 229-bed domiciliary, and has inpatient bed programs that provide medical, psychiatric, and nursing home care. The facility also provides specialized care in geriatrics, substance abuse, post-traumatic stress, and women's health. Three community-style living programs for discharged veterans are operated on the grounds of the medical center through sharing agreements.

Affiliations and Research. For nursing programs, the medical center maintains affiliations with Villanova University, Temple University, West Chester University, Immaculata University, Wilmington College, and Brandywine Hospital School of Nursing. Physician assistant affiliations are held with Hahnamann University and the Philadelphia College of Osteopathic Medicine. Other affiliations with major universities are in clinical fields such as psychology, social work, physical therapy, and speech pathology. In fiscal year (FY) 2004, the facility research program had 33 projects and a budget of $820,922. Important areas of research include post-traumatic stress, neuroscience, clinical drug trials, and dietetic studies.

Resources. In FY 2004, facility medical care expenditures totaled $120.2 million. The FY 2005 medical care budget is $127.9 million, 6.4 percent more than FY 2004 expenditures. FY 2004 staffing was 1,158.4 full-time equivalent employees (FTE), including 32.1 physician FTE and 345.3 nursing FTE.

Workload. In FY 2004, the facility treated 22,754 unique patients, a 3.2 percent increase from FY 2003. Inpatient care workload totaled 2,734 discharges, and the average daily census including the nursing home and domiciliary was 462 patients. Outpatient workload was 157,762 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 health care 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 activities:

Accounts Receivable	Information Technology Security
Agent Cashier	Medical Care Collections Fund
Colorectal Cancer Management	Prescription Drugs
Contracting	Pressure Ulcer Management
Environment of Care	Quality Management Program
Government Purchase Cards	

The review covered facility operations from FY 2003 through April 30, 2005, 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.

Follow-Up to Previous CAP Recommendations

We followed up on five recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Coatesville VA Medical Center*, Report No. 03-02278-08, October 29, 2003). Management adequately addressed four of the recommendations. We made follow-up recommendations in this report related to controlled substances security.

Results of Review

Opportunities for Improvement

Prescription Drugs – Veterans Health Administration Policy and Drug Enforcement Administration Regulations Needed To Be Adhered To

Conditions Needing Improvement. VHA policy and DEA regulations require VA facilities to establish a system of internal controls to maintain accountability over controlled and non-controlled substances. Improvements were needed in:

- Documentation for controlled substances
- Inventory adjustments for controlled substances
- Reporting of controlled substances discrepancies
- Controlled substances inspections
- Receipting for controlled substances
- Disposal of controlled substances
- Timeliness of 72-hour inventories of controlled substances
- Physical security of controlled substances
- Independent oversight of pharmacy activities

Documentation for Controlled Substances. Pharmacy Service staff are required to account for all controlled substances. During our CAP review, Pharmacy Service staff did not always accurately document inventories of controlled substances, and a supply of controlled substances was maintained at a CBOC without the knowledge of Pharmacy Service staff.

- Pharmacy Service inventory records, dispensing records, and records of inventory adjustments for methadone could not be reconciled. Multi-dose bottles from drug manufacturers often contain overfills of the drug solutions. A manufacturer overfilled a bottle of 500mg/500ml methadone solution by 20mg/20ml, but this overfill was not documented by Pharmacy Service staff. Subsequent to our review, Pharmacy Service staff provided us with the "Daily Activity Log" that documented the methadone overage.
- For over 2 years, Pharmacy Service staff lost accountability of controlled substances that were being maintained at the Philadelphia CBOC. On March 23, 2005, during a routine security inspection, medical center police reported that they found controlled substances at the CBOC. On March 31, 2005, the medical center police and the Chief of Pharmacy Service visited the CBOC with the intent of retrieving the controlled

substances. They found 51 of the 100 15mg capsules of the controlled substance temazepam that had originally been dispensed on January 6, 2003, to a physician at the CBOC. The use of the remaining 49 capsules was not documented in the inventory records. After our CAP review, Pharmacy Service staff provided documentation showing that the 49 capsules of temazepam were prescribed to 3 patients who were treated at the Philadelphia CBOC.

Inventory Adjustments of Controlled Substances. From January to December 2004, Pharmacy Service staff made 1,043 adjustments to controlled substances inventory records. These adjustments were the result of findings during monthly controlled substances inspections, returns, wastage, stocking point of service dispensing devices, or dispensing or mathematical errors by pharmacy and nursing staff. VHA policy requires that a two-person signature system be used to document all adjustments in controlled substances inventories caused by accidental loss, breakage, or destruction, and states that this system be strictly enforced. For 136 of the 1,043 adjustments, such losses had occurred and, thus, necessary inventory adjustments required 2 signatures. At the time of our review, we were not provided documentation that demonstrated a two-person signature was used when making inventory adjustments based on accidental loss, breakage, or destruction. Subsequent to our review, we were provided documentation showing that the 136 adjustments did have the required 2 signatures.

In addition, controlled substances inspectors did not review inventory balance adjustments during monthly controlled substances inspections and, in fact, did not have access to records of balance adjustments made by Pharmacy Service staff. The Chief of Pharmacy Service reviewed all balance adjustments monthly, referred her findings to the Controlled Substances Coordinator (CSC) for trending, and certified all adjustments as correct in a blanket statement included in monthly controlled substances inspection reports. The Chief of Pharmacy Service stated that controlled substances inspectors did not have access to balance adjustments because inspectors with no background in pharmacy operations would not understand the reasons for the adjustments. This practice was not in accordance with VHA policy.

VHA policy requires that all balance adjustments must be reviewed during the monthly inspection process. In addition, VHA policy requires the Chief of Pharmacy Service to review all narcotic balance adjustments monthly and report any discrepancies to the CSC. However, neither criterion states that the monthly review by the Chief of Pharmacy Service can or should substitute for the review of adjustments during the monthly controlled substances inspections. Therefore, medical center practice did not meet the intent of VHA policy because it did not provide for independent review of adjustments. We reviewed this practice with program officials in the VHA Pharmacy Benefit Management Strategic Health Group, and they agreed that this practice did not comply with VHA policy and that controlled substances inspectors should have access to inventory balance adjustments during monthly controlled substances inspections.

Reporting of Controlled Substances Discrepancies. VHA policy requires that the CSC notify the medical facility Director of recurring shortages that constitute a pattern of discrepancies, the loss of several doses of a controlled substances, or indications of theft. The policy also requires that the Director then notify the medical center police and the VA OIG Office of Investigations.

The medical center Chief of Police stated that he was not notified of any discrepancies in controlled substances inventories for calendar year 2004 until April 2005, when the Chief of Pharmacy Service provided a list of 1,043 adjustments reported during the year. Not all adjustments required referral to the medical center police or the OIG. However, according to VHA policy some of the adjustments noted on medical center "Controlled Substances Deficiency Reports" and reports of monthly controlled substances inspections from calendar year 2004 through January 2005 should have been referred to the medical center police and the OIG for investigation. Documentation provided by the Chief of Pharmacy Service showed numerous discrepancies that were not reported to the Chief of Police until April 2005. In addition, resolution of the discrepancies was not documented. For example:

- There were 22 discrepancies between quantities on hand of lorazepam and inventory records. These discrepancies constituted a reportable pattern and should have been referred for investigation.
- There were 10 discrepancies between quantities on hand of morphine and inventory records. These discrepancies constituted a reportable pattern and should have been referred for investigation.
- There were 23 discrepancies between quantities on hand of clonazepam and inventory records. The controlled substances inspectors recommended in January and March 2005 that the medical center police be notified, but did not recommend that the OIG be notified. The medical center police were not notified until April 2005.
- There were 14 instances when nursing staff withdrew controlled substances from inventories but administration of the substances to patients was not documented in medical records.
- In May 2004, a controlled substances inspection report noted that a controlled substances inspector was alleged to have transported acetaminophen with codeine (dosage not noted in the report) to the medical center from the Springfield CBOC in April 2004. The May 2004 "Controlled Substances Deficiency Report" reported this as the reason for a 20-dose shortage of acetaminophen with codeine at the CBOC.
- The May 2004 inspection report attributed a 10-dose discrepancy between quantity on hand of lorazepam 1 mg and inventory records to the failure of a pharmacist to fill a patient's prescription.
- In May 2004, 46 tablets of hydromorphone 8 mg were "reserved for destruction" but not deducted from inventory records and secured for destruction.

- The June 2004 controlled substances inspection report reported that 30 tablets of methadone HCL 10 mg and 30 tablets of methadone HCL 5 mg were deducted twice from pharmacy inventories, but not deducted from the inventory records. Controlled substances inspectors recommended that the Chief of Pharmacy Service counsel Pharmacy Service staff.
- The June 2004 controlled substances inspection report also reported that 14 doses of methadone solution 5 mg/ml were missing. Controlled substances inspectors stated that Pharmacy Service staff said that they had miscounted 3 doses as 17.
- In October 2004, Pharmacy Service staff explained a discrepancy of 28 tablets of clonazepam 1 mg as 14 tablets given to the wrong patient. No further explanation was given, and there was no indication that the patient was contacted about the mistaken dispensing to him of 14 tablets. Documentation available at the time of our review did not explain the remaining 14-dose discrepancy. However, documentation subsequently provided indicated that it was caused by an accounting error.
- In October 2004, the controlled substances inspector requested that a discrepancy of 10 acetaminophen with codeine at the Springfield CBOC be referred to the Chief of Pharmacy Service and the medical center Chief of Police. The Chief of Police did not learn of the discrepancy until April 2005. Controlled substances inspectors reported a 20 mg discrepancy for this same drug at the CBOC in May 2004.
- The November 2004 controlled substances inspection report listed the reason as "unknown" for a 10-dose discrepancy of 10 mg/5 ml and a 4-dose discrepancy of 5 mg/5 ml methadone solutions. Controlled substances inspectors reported the discrepancies to the Chief of Pharmacy Service who discussed the issue with Pharmacy Service staff.

Controlled Substances Inspections. VHA policy states that the CSC and controlled substances inspectors should perform inspections and report unresolved discrepancies to the medical facility Director. However, the CSC and controlled substances inspectors did not perform their function independently of the Chief of Pharmacy Service. We asked the CSC why he had not referred questionable adjustments, patterns of discrepancies, lapses in security, and questionable dispensing practices detailed above to the Medical Center Director for referral to medical center police and the OIG as required. We also asked why the controlled substances inspectors did not review all adjustments monthly as required. He stated that he had been instructed by the Staff Assistant to the Medical Center Director and the Associate Chief of Staff for Ambulatory Care to resolve discrepancies with the Chief of Pharmacy Service. A review of medical center "Controlled Substances Deficiency Reports" verified that the CSC did refer discrepancies identified during controlled substances inspections to the Chief of Pharmacy Service for resolution or corrective actions. However, this practice did not always resolve discrepancies. According to entries in "Controlled Substances Deficiency Reports," the Chief of Pharmacy Service did not believe that some discrepancies found during monthly

inspections were reportable, a position that the CSC sometimes disputed. As a result, the discrepancies were never reported, and the CSC's concerns were not addressed. For example, the "Controlled Substances Deficiency Report" for January–March 2005, documented that the Chief of Pharmacy Service and the CSC disagreed strongly about a discrepancy. The CSC wrote: "CSC rebuts the Chief, Pharmacy Service's statement provided above. Documentation of a loss does not negate the fact that a controlled substance was missing without cause or reconciliation. Police action should be initiated." In addition, controlled substances inspectors identified patterns of discrepancies for three controlled substances that occurred during 2004 that they stated should be reported and identified reportable discrepancies at the Springfield CBOC. These discrepancies were not reported to medical center police.

According to the Chief of Pharmacy Service, the CSC trends and tracks discrepancies and reports any trends to the Medical Center Director and the medical center police. This assertion was a contradiction considering that discrepancies or inventory adjustments found during the monthly narcotic inspections were not reported to the Chief of Police until April 2005.

Receipting for Controlled Substances. VHA policy requires that the Accountable Officer or his designee:

- Witness the opening of cartons and acknowledge receipt of controlled substances by Pharmacy Service staff.
- Document receipt of controlled substances on appropriate forms.
- Verify and document that controlled substances have been placed into inventory.
- Reconcile any discrepancies before Pharmacy Service staff place stock into inventory.

The Accountable Officer did not witness the receipt of delivery of controlled substances, verify that delivered controlled substances were placed into inventory, or reconcile discrepancies before deliveries of controlled substances were placed into inventory.

Disposal of Controlled Substances. Pharmacy Service staff did not adequately document the transfer of controlled substances to a third party distributor for destruction. VHA policy allows facilities to employ a third party distributor who is licensed by DEA to destroy expired or unneeded controlled substances and this is the method of destruction used at the medical center. The distributor used DEA Form 222 "U.S. Official Order Forms – Schedules I & II" to document transfers of Schedule I and II controlled substances. In addition, the distributor generated other reports to document the transfers of Schedules III, IV, and V controlled substances that Pharmacy Service staff maintained. Our review showed that DEA Form 222 was not completed when 22 Schedule II drugs were transferred to the distributor for destruction.

DEA Forms 222 documenting transfers of Schedule I and II controlled substances to the distributor for destruction from October 1, 2004, to March 22, 2005, did not include 22 of 70 Schedule II substances listed by the distributor's transfer reports as being received for destruction from Pharmacy Service staff. Therefore, we could not account for the 22 controlled substances. Subsequent documentation provided by the Chief of Pharmacy Service did not show that the 22 Schedule II drugs we identified during our review were listed on DEA Forms 222 as required by DEA.

In addition, Pharmacy Service staff and the distributor did not properly document the transfers of Schedule II, III, IV, and V controlled substances from the medical center to the distributor. Our review of four transfer reports that were executed between October 1, 2004, and March 22, 2005, showed that the distributor did not sign one of the transfer reports and Pharmacy Service staff authorized to sign for the transfers counter-signed just one of the transfer reports.

Timeliness of 72-hour Inventories of Controlled Substances. VHA policy requires that Pharmacy Service staff inventory controlled substances every 72 hours. From November 1, 2004, to April 30, 2005, Pharmacy Service staff did not perform 8 (14 percent) of 58 required 72-hour inventories.

Physical Security of Controlled Substances. VHA policy requires that some medical facilities store a cache of pharmaceuticals reserved specifically for a weapons of mass destruction event that disrupts deliveries to the hospital. Caches of controlled substances are to be stored in the controlled substances vault in locked containers identified with tags. Our physical inspection showed that the containers were not secure and that drugs could be removed. While the method employed at the medical center for storing and securing cache drugs is not in violation of VHA policy, it does differ from methods employed at other medical centers we have reviewed, where containers were sealed twice to prevent unauthorized entry.

In January 2005, medical center police were notified that a nurse had been using another nurse's personal identification number (PIN) to access controlled substances secured in nursing unit controlled substances dispensing devices. The police investigation disclosed that the inappropriate use of the PIN had occurred over an 18-month period. We were provided documentation by medical center management showing that they had initiated administrative action against the two nurses.

Independent Oversight of Pharmacy Activities. VHA policy requires oversight by staff from non-pharmacy functions to ensure that accountability for controlled substances is independently documented. Throughout the review, we identified a pattern of Pharmacy Service staff receiving, adjusting, turning-in, and disposing of controlled substances without the independent oversight of the controlled substances inspectors, witnesses, or second parties required by VHA policy and DEA regulations. For example, controlled substances inspectors did not document the removal of controlled substances from

pharmacy stock, and nursing staff did not document turn-ins of unusable controlled substances from patient care areas.

The involvement of the CSC and the Chief of Police in activities such as balance adjustments and discrepancies noted by monthly inspectors would show oversight independent of pharmacy management and staff. In addition, monthly inspectors having access to balance adjustments and the timely reporting of control substances discrepancies would constitute steps to verify independent oversight of pharmacy activities.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that:

(a) controlled substances inventories are accurately documented;
(b) controlled substances inventory adjustments are documented with two-person signatures when required and reviewed during controlled substances inspections;
(c) questionable discrepancies and patterns of discrepancies in controlled substances inventories are referred to medical center police and the VA OIG Office of Investigations;
(d) monthly controlled substances inspections are improved;
(e) the Accountable Officer documents oversight of the receipt of controlled substances;
(f) controlled substances are disposed of in accordance with VHA policy and DEA regulations;
(g) 72-hour controlled substances inventories are conducted timely;
(h) controlled substances are physically secure, which includes monitoring the use of PINs; and
(i) required witnesses and second parties from non-pharmacy functions provide oversight of pharmacy activities.

The VISN and Medical Center Directors agreed with the findings and recommendations. Pharmacy Service staff will ensure that controlled substances inventories are accurately documented and when required, inventory adjustments are documented with two-person signatures. A policy implemented by the Medical Center Director provided instructions for dealing with discrepancies noted during monthly inspections and the subsequent reporting of any unresolved discrepancies. The CSC will trend and track discrepancies and report any trends to the Medical Center Director and the medical center police. The Accountable Officer will witness the opening of cartons, acknowledge receipt, and witness the controlled substances placement into inventory. Pharmacy Service staff will complete the 72-hour inventories at least three times a week. Disciplinary actions were taken against the staff for inappropriate use of their Omni-cell PINs, and software enhancements now compel users to change their PINs every 90 days. There are required witnesses and second parties from non-pharmacy functions to provide oversight of

pharmacy activities. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Medical Care Collections Fund – Fee-Basis Billing Procedures, Medical Record Documentation, and Medical Record Coding Needed Improvement

Condition Needing Improvement. Under the MCCF program, VA is authorized to bill third party health insurance and Tricare, a program that provides health care coverage to active duty and retired military personnel and their families, for health care provided to veterans. VA is required by Federal law to set charges according to the "Schedule of Reasonable Charges" published in the Federal Register, although those charges can differ significantly from VA's costs. In FY 2004, the medical center collected $6,206,348 through MCCF, exceeding the goal of $6,028,700 established by VISN 4. However, MCCF staff did not always bill for fee-basis care provided to veterans with health care coverage. In addition, billing, medical record documentation, and medical record coding of other billable cases needed improvement.

Fee-Basis Billing Procedures. From October 1, 2004, to December 31, 2004, the medical center paid 33 fee-basis claims totaling $182,162 to private providers for care provided to veterans covered by third party insurance or Tricare. To determine if the medical center had billed for this care, we reviewed a random sample of 6 inpatient and 20 outpatient fee-basis payments. One payment for an inpatient case and all 20 payments for the outpatient cases were either properly billed or were not billable. However, five of the six inpatient payments should have been billed:

- MCCF staff did not bill third party insurance for reasonable charges of $111,863 for two fee-basis payments for emergency treatment provided by a community hospital to a contract nursing home care patient.
- MCCF staff did not bill third party insurance for reasonable charges of $1,360 for treatment because the "Potential Cost Recovery Report" did not include the veteran's insurance information.
- MCCF staff did not bill Tricare for reasonable charges of $108,108 for medical care for two military retirees with Tricare coverage. MCCF staff did not bill Tricare as they assumed Tricare would not reimburse VA for fee-basis care.

The MCCF Coordinator agreed that these payments should have been billed, and instructed MCCF staff to bill third party carriers and Tricare for $221,331 ($111,863 + $1,360 + $108,108) for these five payments while we were onsite.

Billing, Medical Record Documentation, and Medical Record Coding. The May 3, 2005, "Reasons Not Billable Report" for October 1, 2004, to December 31, 2004, listed 10 outpatient cases where MCCF staff did not bill third party carriers for care provided to

veterans. A review of the 10 cases showed that MCCF staff should have billed insurers $3,114 in 7 instances.

- In three cases, MCCF staff identified the cases as billable but had not followed up and issued bills totaling $2,193.
- In three cases, MCCF staff should have billed $705, but medical record coding staff in the Medical Information Management Section had placed the cases in suspense because of inadequate medical record documentation. When we brought these three cases to the attention of the MCCF Coordinator, coding staff obtained sufficient documentation to bill.
- In one case, the coder overlooked documentation in the medical record that an electrocardiogram had been performed. Therefore, MCCF staff did not bill the carrier for $216.

The MCCF Coordinator agreed with our assessments, and established bills for the seven outpatient episodes totaling $3,114.

Improved billing for fee-basis care, better medical record documentation, and improved medical record coding would have enhanced MCCF collections. Based on potential billable cases of $224,445 ($221,331 + $3,114) and the medical center's FY 2005 accounts receivable collection rate of 27.2 percent, we estimated that the medical center could collect an additional $61,049 ($224,445 x 27.2 percent).

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish bills for fee-basis payments for care provided to veterans and military retirees with health care coverage, (b) ensure that MCCF staff adequately follow up all billable cases, (c) ensure that adequate documentation is entered into medical records to support billings, and (d) ensure that medical record coding staff identify all billable care.

The VISN and Medical Center Directors agreed with the findings and recommendations. MCCF employees were instructed to review "Fee Basis Payment" listings and "Potential Cost Recovery Reports" on an ongoing basis, and billing and coding activities were enhanced through improved procedures and the assignment of a Fee Basis Clerk with certification as a medical record coder. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Agent Cashier – Duties Needed To Be Segregated and the Cash Advance Needed To Be Reduced

Condition Needing Improvement. Physical security of the Agent Cashier area was adequate. An unannounced audit of the Agent Cashier advance caused by OIG staff identified no cash shortages or overages and safe combinations and duplicate keys for

cash boxes were appropriately secured in the custody of the Medical Center Director. However, there was inadequate segregation of duties for the primary Agent Cashier and three MCCF clerks who also had Cashier Class D designations, a basic, limited Agent Cashier authority. The amount of the Agent Cashier advance also needed to be reduced.

Agent Cashier Segregation of Duties. VA policy states that employees who collect revenue should not also maintain or be in a position to adjust related accounting records. However, the primary Agent Cashier had access to MCCF accounts receivable records that enabled her to establish and post to the accounts. Because the Agent Cashier received payments and prepared deposits for these accounts, she had the ability to both receive payments via cash or check and to post to corresponding accounts. While we were onsite, the medical center's Chief Financial Officer (CFO) initiated action to disable the electronic menu options that allowed the Agent Cashier to post to accounts receivable.

MCCF Clerk Segregation of Duties. As MCCF clerks, these employees established, maintained, waived, terminated, and re-established MCCF accounts receivable. As Agent Cashiers, they received veteran co-payments and third party payments for MCCF. According to the CFO, the clerks had been given Agent Cashier authority about a week before our review to alleviate an ongoing backlog in processing MCCF payments. However, having the ability to both receive MCCF payments and to post to MCCF accounts receivable conflicted with VA policy on segregation of duties. While we were onsite, the CFO directed the MCCF clerks to discontinue disbursing and receiving cash and limited their access to the Agent Cashier area to receiving mailed checks, copying checks, and picking up receipts for posting to accounts receivable.

Agent Cashier Advance. VHA policy states that the Agent Cashier advance should not exceed the medical facility's actual cash needs. The amount of the Agent Cashier advance was excessive because the Agent Cashier was processing cash payments for veterans participating in the medical center's Compensated Work Therapy (CWT) program. Medical center policy required veterans enrolled in the CWT program to save 70 percent of their pay by depositing the funds in accounts at a bank or credit union, or in medical center Personal Funds of Patients (PFOP) accounts. This was done to show veterans the advantages of a saving program and to provide them with funds for living expenses upon discharge from the medical center. To facilitate this process, the Agent Cashier paid program participants in cash. Because most veterans opted to deposit their saved funds in PFOP accounts, they immediately returned 70 percent of the cash remitted to them back to the Agent Cashier for deposit in a second transaction.

The Agent Cashier's advance at the time of our review was $58,500, and it was partially justified by transactions with patients in the CWT program totaling about $25,000 every 2 weeks. Electronically transferring CWT payments to PFOP accounts, banks, or credit unions would allow for a reduction in the Agent Cashier's advance. Excluding CWT transactions, the Agent Cashier's payments totaled $291,365 from April 1, 2004, through

March 31, 2005. Applying the turnover rate of 12, the minimum rate identified in VHA policy, the cash advance could be decreased to $24,280 ($291,365 ÷ 12), a reduction of $34,220. The CFO agreed with our assessment, and was taking steps to provide for electronic transfers of funds for CWT patients to allow reduction of the Agent Cashier advance.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) terminate the Agent Cashier's access to post transactions to accounts receivable, (b) rescind Agent Cashier designations for MCCF clerks, and (c) reduce the Agent Cashier advance to $24,280.

The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center management terminated the Agent Cashier's ability to post to accounts receivable and rescinded the MCCF clerks' Agent Cashier designations. Management also reduced the Agent Cashier advance. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Accounts Receivable – Follow-Up of Department of Defense Accounts Receivable Needed Improvement

Condition Needing Improvement. Most accounts receivable were established timely and were aggressively pursued for collection. However, Fiscal Service staff had not aggressively pursued DoD accounts receivable established under Tricare. Follow-up of DoD accounts receivable was especially important because a second, newer DoD program, Tricare for Life (TFL) had increased the number of DoD accounts receivable established by the medical center.

DoD pays VA for health care provided to active duty and retired military personnel and their families. Tricare pays for active duty and retired personnel and TFL pays for military retirees and their spouses and survivors aged 65 and older who are eligible for Medicare Part A and who are enrolled in Medicare Part B. TFL was enacted in October 2001, but according to the MCCF Coordinator MCCF staff did not immediately begin billing DoD for these cases because staff at the medical center was unsure whether VA was authorized to bill DoD under TFL given that VA was not authorized to bill Medicare. To address this question nationally, in November 2004 the VHA Chief Business Officer instructed VHA medical facilities to bill DoD under the auspices of TFL, and MCCF staff began billing TFL in March 2005.

Limited Follow-Up of Tricare Accounts Receivable. While MCCF staff billed DoD for care provided to active duty military and their families under Tricare, after MCCF staff established accounts receivable for these cases follow-up was limited. The MCCF Coordinator stated that only those Tricare accounts receivable that generated correspondence from DoD received follow up. If neither payment nor correspondence

from DoD was received within 120 days, the account was written off. The medical center's Chief Accountant stated that although there was no medical center policy concerning writing off these accounts, medical center and Fiscal Service management placed a higher priority on collection of other accounts receivable because of their higher dollar value when compared to Tricare accounts receivable.

Billing for TFL Increases DoD Accounts Receivable. From January 1, 2004, through April 30, 2005, 55 Tricare accounts receivable were established valued at $3,204 and all or part of 39 (71 percent) of the 55 accounts valued at $1,410, (44 percent of their value) were written off. However, since receiving the November 2004 guidance from VHA, Fiscal Service staff started billing DoD and establishing accounts receivable for care provided to retirees with TFL coverage. In March and April 2005, Fiscal Service retrospectively established 212 accounts receivable with a value of $48,172 for medical care provided from December 2003 through April 2005. Because far more military retirees than active duty personnel are treated by the medical center, the number of DoD accounts receivable requiring follow-up could be expected to increase significantly, as medical center staff continues to identify those medical center patients with TFL coverage. Established Federal accounts receivable are considered 100 percent collectible. Therefore, it is important that DoD accounts receivable are followed up with the same degree of persistence given to other accounts receivable.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director take action to (a) end the local practice of writing off Tricare accounts receivable after minimal follow-up and (b) aggressively pursue follow-up of both Tricare and TFL accounts receivable.

The VISN and Medical Center Directors agreed with the findings and recommendations. The Medical Center Director appointed additional staff to provide for aggressive follow-up of Tricare and TFL accounts receivable. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Government Purchase Cards – Cardholders Should Not Split Purchases

Condition Needing Improvement. VA policy requires that Government purchase card transactions be reconciled within 30 days and approved within 14 days. VA policy also requires that no purchases be made from individuals or companies on the Health and Human Services (HHS) excluded vendors list. A review of a sample of 50 transactions with a value of $25,892 completed from October 1, 2003, to March 31, 2005, showed that medical center staff reconciled and approved transactions timely. In addition, a review of a sample of 30 other transactions with a value of $27,135 completed during the same period showed that medical center staff made no purchases from vendors on the HHS

excluded vendors list. However, a cardholder split one purchase to circumvent a purchase card limitation.

VA policy precludes cardholders' from splitting larger purchases into smaller ones to circumvent limitations on individual purchase cards. We reviewed a sample of 10 potential split purchases that occurred from October 1, 2003, to March 31, 2005, and found that 1 cardholder generated 2 transactions ($4,800 for $2,400, respectively) to purchase echocardiogram interpretations that together exceeded the $2,500 purchase card limitation. The Purchase Card Coordinator agreed that the purchase had been split, and stated that a backlog necessitated splitting the purchase because the dollar value of the purchase exceeded the limit on the cardholder's card. The purchase should have been given to another cardholder whose card had a higher limit.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that cardholders not split purchases to circumvent purchase card limitations.

The VISN and Medical Center Directors agreed with the finding and recommendation. Medical center management directed that training be provided to individuals with purchase cards regarding avoidance of split purchases, and future training and audits will emphasize avoidance and detection of split purchases. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Information Technology Security – Required Security Information Should Be Submitted to the Veterans Health Administration

Condition Needing Improvement. Information technology (IT) security controls were adequate for inactive user accounts, security awareness training, virus protection, password controls, and computer room security. However, there was one area where management could improve IT security.

VA's Assistant Secretary for Information and Technology has issued authority to the VHA VistA Imaging Program Officer (VIPO) to operate VistA Imaging nationally rather than issue authorizations to individual VHA facilities. VistA Imaging is a process that electronically transfers medical imaging procedures such as radiographic examinations from the facility where the procedures were performed to a second location where they can be interpreted by a physician. The national security plan for VistA is maintained by VIPO, and individual VHA facilities must submit information such as key personnel, backup and restore capabilities, and security processes to VIPO every 3 years to ensure that the national security plan is complete and accurate. The medical center's Information Security Officer (ISO) had not submitted this information to VIPO when VistA Imaging was initially certified in 2002, or at any time since initial certification.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director takes action to submit required security information to the VHA VIPO.

The VISN and Medical Center Directors agreed with the finding and recommendation. While the OIG was onsite, the facility completed a VistA site security plan and submitted required security information to the VHA VIPO. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Quality Management – Root Cause Analyses Needed Improvement

Condition Needing Improvement. The medical center QM program was comprehensive and generally provided appropriate oversight of patient care in 11 of the 12 areas reviewed. However, the RCA teams did not always:

- Identify root causes for all reportable occurrences when appropriate.
- Generate recommendations that directly addressed problems cited.
- Establish measurable outcomes.
- Document improvement actions.
- Monitor effectiveness of improvement actions.

We reviewed 13 RCAs that resulted in multiple recommendations. Three of the analyses did not identify any trends, and in other instances, RCA teams recommended policy changes or the need for additional employee training that did not directly address the problems. Ten recommended monitoring actions generated by RCA teams identified start dates and the parties responsible for implementing corrective actions, but did not identify the means of measuring compliance with recommendations or dates to re-evaluate compliance. Two recommended actions were never implemented.

Recommendedation 7. We recommended that the VISN Director ensure that the Medical Center Director implements procedures to: (a) consistently analyze RCA data and identify opportunities to improve the quality of patient care, (b) monitor the implementation of recommendations from RCA reviews, and (c) ensure that responsible parties are accountable for implementing improvements and reporting the effectiveness of corrective actions.

The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center management made improvements in RCA team reporting and timeliness and documentation of responsibility for monitoring follow-up to recommendations. Training was provided to all staff involved in overseeing the RCA process. Medical center management planned to evaluate the effectiveness of these changes in December 2005. The implementation plans are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Appendix A

VISN 4 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 18, 2006

From: Director

Subject: Combined Assessment Program Review of the VA Medical Center Coatesville, Pennsylvania

To: Assistant Inspector General for Auditing (52)

As provided in the discussion by the medical center director of the VAMC Coatesville, Pennsylvania, I concur with his comments regarding the final recommendations in the draft report.

(original signed by:)
CHARLEEN R. SZABO, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 10, 2006

From: Director

Subject: Combined Assessment Program Review of the VA Medical Center Coatesville, Pennsylvania

To: Assistant Inspector General for Auditing (52)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program draft report of the Coatesville VA Medical Center. I concur with all of the final recommendations, suggestions and monetary benefits identified in the OIG's report. Along with the concurrences, I have provided some requests for further consideration. Comments and the implementation plan are included with transmittal of this memorandum.

2. Please express my appreciation to the auditors and reviewers who conducted the review during the week of May 16-20, 2005 for their professionalism and efforts to assist in improving the medical center's operations and controls.

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

(original signed by:)

GARY W. DEVANSKY

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

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

OIG Recommendations

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to ensure that:

(a) controlled substances inventories are accurately documented;

Concur **Target Completion Date:** Completed 4/2005

Sealed liquids are placed in inventory according to the volume listed on the label. After opening, any overfill is noted on the inventories.

No controlled substance will be maintained at the CBOCs.

(b) controlled substances inventory adjustments are documented with two-person signatures when required and reviewed during controlled substances inspections;

Concur **Target Completion Date:** Completed 5/2005

The VistA software program includes a balance adjustment option that is used to review or enter adjustments needed to correct the balance of a drug. At the time the balance adjustment is made, the program automatically deducts the controlled substance drugs which are to be destroyed from the on-hand inventory. Once the deduction occurs, a destruction sheet (VAF 10-2638) is automatically printed out. The form requires a two-person signature. The 136 destruction sheets contained two signatures. Information pertaining to the remaining 27 adjustments was provided to the OIG auditor on

5/3/06. Drugs to be destroyed are then stored in the main vault until they are transferred to the destruction company. Monthly inspections are done on these items.

All balance adjustments requiring destruction sheets have destruction sheets printed and contain the two required signatures.

(c) questionable discrepancies and patterns of discrepancies in controlled substances inventories are referred to medical center police and the VA OIG Office of Investigations;

Concur **Target Completion Date:** Completed 10/2005

In April 2005, the Director conducted a meeting with the Controlled Substance Coordinator, Staff Assistant to the Director, Chief, Nurse Executive, and Chief, Pharmacy Service to refine this process. At that meeting the 1,043 balance adjustments from the previous year were reviewed and it was clarified that they were not discrepancies. At that time, it was agreed to report to the police all discrepancies that remained unresolved as of the end of an inspection. The process implemented in April 2005 has included instructions to the monthly inspectors telling them what to do when they encounter an unresolved, actual vs. expected count variance. The instructions indicating they are to send a priority message, containing the variance's specifics, to a mail group that includes the Police Service, Pharmacy, Director's Office and the Controlled Substance Coordinator is included in medical center policy Inspection and Review of Alcohol, Schedule II, III, IV and V Controlled Substances and Drug Records (LD-17).

The expectation is that, if no appropriate reason for a variance can be found, an investigation will be initiated. Also, the Chief of Police with the Controlled Substance Coordinator (acting through the Office of the Director) will report the variance to the OIG.

The monthly Controlled Substance Coordinator's Report of Inspection includes mention of unresolved discrepancies referred to the Police for possible investigation.

As of October 2005, the Narcotic Drug Inspection Summary includes a specific Police update section along with a signature line for the Chief of Police.

(d) monthly controlled substances inspections are improved;

Concur **Target Completion Date:** Completed 5/2005

The inspections are reported to the facility director monthly and trended quarterly. The CSC and the inspectors conduct their inspections independently; but, when there are questions a fact-finding is done. During monthly inspections, attempts are made to find the reason for any discrepancy. This is a joint effort between pharmacy, nursing, and the CSC and narcotic inspectors. The discrepancies noted in the draft report were resolved at the time of the monthly inspections in 2004. (The report mentions that the Chief of Pharmacy did not believe that some significant discrepancies found during monthly inspections were reportable. The case in question occurred in Jan. 2005. There was a lorazepam 0.5mg tab lost during prepacking in the ATC machine. This tablet was documented in the prepack book as being lost. On the quarterly report, the CSC recommended it be referred to the Police.)

The CSC trends and tracks discrepancies and reports any trends to the Medical Center Director and the Police.

(e) the Accountable Officer documents oversight of the receipt of controlled substances;

Concur **Target Completion Date:** Completed 8/2/05

(1) A&MM and Pharmacy have signed a new agreement for an Accountable Officer or designee from A&MM to be available to witness arrival of controlled substances in Pharmacy. The Accountable Officer will witness the opening of the cartons, acknowledge receipt and witness the controlled substances placement in inventory. (2) A copy of this agreement is filed in Pharmacy so staff is aware of who to contact as orders are delivered.

(f) controlled substances are disposed of in accordance with VHA policy and DEA regulations;

Concur **Target Completion Date:** Completed 5/2005

DEA Form 222 and the distributor-generated reports to document the transfer of Schedule III, IV and V controlled substances contain signatures of the third party distributor and CVAMC pharmacy staff.

Copies of the DEA Form 222 and the schedule drug inventory report from EXP Pharmaceutical Services Corp listing the drugs removed from CVAMC were sent to the OIG Auditor (4/6/06).

(g) 72-hour controlled substances inventories are conducted timely;

Concur **Target Completion Date**: Completed 2/2005

Since February 2005, 72-hour inventories have been completed at least three times a week, unless there was a federal holiday during the week.

(h) controlled substances are physically secure, which includes monitoring the use of PINs;

Concur **Target Completion Date:** Completed 1/2005

Controlled substances are and have been, since the cache was received in 2003, stored in the cache vault (locked/secure). The cache meets all regulations for storage. A floor to ceiling cement block vault that meets pharmacy security regulations was constructed.

It was determined in January 2005 that a nurse was using another nurse's PIN to access an Omnicell dispensing unit. The Chief Nurse Executive was notified and in turn she notified the Police immediately. In order to receive PIN numbers to access Omnicells a contract must be signed in Pharmacy. The nurse had used another nurse's PIN in October 2004. The dispensing device's dispensing report was run and the doses retrieved under the wrong PIN were

reviewed and were checked against doses administered. All medications were accounted for.

Nursing took two corrective actions against the nurses involved. Copies of the disciplinary actions against two nurses who used their PINs inappropriately were sent to the OIG Auditor (4/6/06).

Software enhancements to the Omnicells have made password changes mandatory at least every 90 days.

(i) required witnesses and second parties from non-pharmacy functions provide oversight of pharmacy activities.

Concur **Target Completion Date:** Completed 5/2005

Controlled substance inspectors review the overall program on a monthly basis. Documentation is reviewed for procurements and destructions. VISN level inspections are done for the controlled substance program to assess the program's overall compliance with VHA Directive 1108.1 and 1108.2. Non-pharmacy staff review and document receipt of medications that are purchased. Third-party documentation is completed for returns for credit or destruction of controlled substances.

Nursing turn-ins are tracked through VISTA or a return drawer in a point-of-care (POC) machine. The POC's report is attached to corresponding inventory adjustments.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) establish bills for fee-basis payments for care provided to veterans and military retirees with health care coverage;

Concur **Target Completion Date:** Completed 5/2005

Fee Basis Payment Listings are now being reviewed by MCCR throughout the month to identify potential billable episodes.

(b) ensure that MCCF staff adequately follows up all billable cases;

Concur **Target Completion Date:** Completed 5/2005

The Potential Cost Recovery Report is being run and reviewed to cross-reference and coordinate receipt of Fee Basis billable claims. All Fee Basis bills are given to the Lead Biller for establishment of the VA claim.

(c) ensure that adequate documentation is entered into medical records to support billing;

Concur **Target Completion Date:** Completed 5/2005

Through reassignment of people within the Service the Fee Basis Clerk is now a certified coder with the skills to verify adequate documentation, proper coding and the ability to better identify all billable care.

(d) ensure that medical record coding staff identifies all billable care.

Concur **Target Completion Date:** Completed 5/2005

See item c above

Recommended Improvement Actions 3. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) terminate the Agent Cashier's access to post transactions to accounts receivable;

Concur **Target Completion Date:** Completed 5/2005

Agent Cashier's access to post accounts receivable was terminated.

(b) rescind Agent Cashier designations for MCCF clerks;

Concur **Target Completion Date:** Completed 5/2005

MCCF clerks have had designations rescinded.

(c) reduce the Agent Cashier advance to $24,280.

Concur **Target Completion Date:** Completed 5/2005

Agent Cashier advance has been reduced as governed by the fluctuation of the CWT Payroll.

Recommended Improvement Actions 4. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) end the local practice of writing off Tricare accounts receivable after minimal follow-up;

Concur **Target Completion Date:** Completed 5/2005

Aggressive follow-up of Tri-care accounts receivable has been initiated with the filling of a vacancy.

(b) aggressively pursue follow-up of both Tricare and TFL accounts receivable.

Concur **Target Completion Date:** Completed 5/2005

The Tri-care Follow-up Report for Tri-care billings is run each month with follow-up being completed by MCCR A/R staff.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires that cardholders not split purchases to circumvent purchase card limitations.

Concur **Target Completion Date:** Completed 5/2005

A local contract was initiated to alleviate echocardiogram interpretations being processed as a group order eliminating a split order in the future. Education was provided to the individual involved with emphasis to be given to split orders in scheduled training, orientation and audits.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director takes action to submit required security information to the VHA VIPO.

Concur **Target Completion Date:** Completed 5/2005

In 2002 VISN 4 started a project to implement Vista Imaging in the Medical Centers and the ISO was chosen to be the Point of Contact for Coatesville. Throughout the implementation process there were monthly conference calls and numerous documents were submitted but this information was never required. Since Vista Imaging is part of our medical center's Vista system and the hardware is located in the computer room we had to prepare an addendum to our Vista Site Security Plan. During the OIG CAP Inspection the inspector asked about our Vista Imaging Site Specific SSP. Before Thursday afternoon they were given our plan (see attached). Our documents have since been submitted to the VHA Vista Imaging Program Office.

Recommended Improvement Actions 7. We recommend the VISN Director ensure that the Medical Center Director implements procedures to:

(a) consistently analyze root cause analysis data and identify opportunities to improve the quality of patient care; (b) monitor the implementation of recommendations from root cause analysis reviews; (c) ensure that responsible parties are accountable for implementing improvements and reporting the effectiveness of corrective actions.

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

Actions Completed: Medical Center senior leadership identified the need to improve and had begun to implement changes in the root cause analysis process prior to the OIG/CAP review. On May 4, 2005 senior leadership and Quality Improvement/Patient Safety met to identify improvement opportunities and agree on a course of action. Major changes to the RCA process that were made that day include:

1) All RCA teams meet with the quadrad and Patient Safety Manager at their launch. Team members are made aware of the high priority of their RCA assignment and are given guidance to ensure supervisory support. They are asked to think creatively, given resources to contact, and informed

of the importance of their work to the medical center's mission. Specifically they are asked to probe deeper for root causes if/when they arrive at commonly and often-incorrect causes of lack of education, policy or staff.

2) Rather than waiting until the RCA is completed to do management review for concurrence, teams are instructed to bring their draft report forward in 21 days or sooner for that review. This is intended to address analyses in which no root causes can be identified as well as provide the teams with greater opportunity to garner management support and guidance in uncovering root causes, developing recommendations and establishing measurable outcomes.

3) A timeline detailing responsibilities of all involved individuals is reviewed with the team by the quadrad and PSM.

Responsibility for monitoring the implementation of recommendations as well as reporting on the effectiveness of actions taken are included in the timeline.

In addition to the above improvement plan, all staff who will be responsible for chairing RCA teams was given training by the National Center for Patient Safety on June 29, 2005, at CVAMC.

Senior management evaluated the effectiveness of changes made to CVAMC's RCA process in December 2005.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Improving fee-basis billing, documentation, and MCCF coding would enhance collections.	$61,049
3	Reducing Agent Cashier advance would improve cash management.	34,220
	Total	$95,269

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr. (708) 202-2667
Acknowledgments	Donald Bunce Larry E. Chinn Kevin Gibbons Donna Giroux, R.N. Cynnde Nielsen Walter Pack Randall Snow, J.D. David M. Spilker Carol Torczon, R.N. William Wells

Appendix E

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