Department of Veterans Affairs
Office of Inspector General

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

Report No. 07-00578-164 **July 10, 2007**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high-quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities 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 services.
- 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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of April 23–27, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Canandaigua VA Medical Center (the medical center) in Canandaigua, NY. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 184 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Results of Review

We identified the following organizational strength:

- An infection control (IC) initiative improved employee compliance with the Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and Joint Commission's IC patient safety goal.

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

- Community Based Outpatient Clinics (CBOCs).
- Survey of Healthcare Experience of Patients (SHEP).

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

- Improve compliance with the Veterans Health Administration (VHA) directive governing computer flags for patients at risk for suicide and trend and report emergency response data according to facility policy.
- Improve medication refrigerator temperature monitoring, ensure expired medications are returned to the pharmacy, and ensure that water quality data is obtained and analyzed.
- Review Computerized Patient Record System (CPRS) business rules annually to ensure compliance with VHA regulations.

There were no health care related recommendations from the previous CAP report (*Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 04-01562-35, November 26, 2004).

This report was prepared under the direction of Ms. Katherine Owens, MSN, Boston Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations. They provided acceptable improvement plans. (See Appendixes A and B, pages 10–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by Dana Moore, Ph.D., Deputy Assistant Inspector General for Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Facility Profile

Organization. Located in Canandaigua, NY, the medical center is a psychiatric and long-term care facility. It has one CBOC located in Rochester, NY. The medical center serves a veteran population of over 76,000 from Monroe, Ontario, Seneca, Wayne, and Livingston counties in upstate New York. The medical center is under the jurisdiction of VISN 2.

Programs. The medical center provides long-term nursing home care, long-term psychiatric care, outpatient psychiatric care, primary care, physical medicine and rehabilitation services, and dental services. Other services include domiciliary care, dementia care, a partial hospitalization program, and a homeless outreach program.

Affiliations and Research. The medical center maintains an affiliation with the University of Rochester School of Medicine and Dentistry and supports five medical resident positions. It also serves as a training site for nursing, social work, physician assistants, and other professional and technical related disciplines.

The medical center does not have a research budget but uses Syracuse VA Medical Center's research structure; this allows the medical center's clinical employees to participate in research projects. Current areas of research include chiropractic care, post-traumatic stress disorder care, and geriatric care.

Resources. The medical center's budget for fiscal year (FY) 2006 totaled approximately $79 million. The FY 2007 budget totaled approximately $80 million. FY 2006 staffing was 724 full-time employee equivalents (FTE). FY 2007 staffing is 741 FTE, which includes 68 physician and 255 nursing FTE.

Workload. In FY 2006, the medical center treated over 17,700 unique patients. The medical center had 20 operating psychiatry beds in FY 2006, with an average daily census of 10 (the facility closed these beds in March 2007). In FY 2006, there were 138 operating nursing home beds, with an average daily census of 109, and 50 operating domiciliary beds, with an average daily census of 40. Additionally, in FY 2006, the medical center had 30 operating Psychosocial Residential Rehabilitation Treatment Program beds, with an average daily census of 24. The outpatient workload for FY 2006 totaled over 196,000 visits.

Objectives and Scope of the Combined Assessment Program 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. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- 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 activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following activities:

CBOC	QM Program
CPRS Business Rules	SHEP
Environment of Care (EOC)	

The review covered facility operations for FY 2006 and FY 2007 through March 31, 2007, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

There were no health care related recommendations from the previous CAP report (*Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 04-01562-35, November 26, 2004).

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 184 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report, we summarized selected focused inspections and made recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the Other Areas Reviewed section have no reportable conditions.

Results of Review

Organizational Strength

Hand Hygiene Initiative Was Effective.

The CDC developed hand hygiene guidelines, and the Joint Commission adopted compliance with the guidelines as a patient safety goal. The Joint Commission's rationale was that compliance with the CDC hand hygiene guidelines would reduce the transmission of infectious agents by staff to patients and decrease the incidence of health care associated infections.

The medical center's IC managers organized an IC Champions group in September 2005. The group's first initiative focused on increasing hand hygiene compliance throughout the medical center. The group made 197 observations per month of hand hygiene compliance during FY 2006. Because of the initiative, hand hygiene compliance prior to employees providing patient care increased from 88 percent in the first quarter of FY 2006 to 97 percent in the fourth quarter. Hand hygiene compliance by employees after providing patient care improved from 91 percent to 99 percent within the same timeframe. The facility maintained this improvement through the first and second quarters of FY 2007.

Opportunities for Improvement

Quality Management Program

The medical center's QM processes were generally satisfactory, and senior managers supported the program through participation in performance improvement activities and allocation of resources. We identified two areas that needed management attention.

Conditions Needing Improvement. Medical center managers needed to ensure that patients with known suicidal behavior have appropriate flags placed in their medical records, as required by VHA Directive 2003-048, *National Patient Record Flags*. VISN and medical center managers also needed to ensure that their policies related to suicidal behavior comply with this directive.

Additionally, managers needed to analyze medical emergency response performance data and report the data to an appropriate monitoring committee, in accordance with the facility's policy.

Medical Record Flags. VHA regulations require that patients who are dangerous to themselves or others have computer-based advisories, referred to as "Patient Record Flags (PRFs)," placed in their medical records to alert clinicians to the risk of violence.

The directive distinguishes between Category I and Category II PRFs. According to the directive, a history of suicidal or para-suicidal behavior requires a Category I advisory. We reviewed a case that involved a patient who made a suicide attempt serious enough to require medical intervention while residing in the medical center in late 2005. The same patient made a suicidal gesture a few months later while an inpatient on the Acute Psychiatry Unit.

During our CAP review, we examined the patient's computerized medical record and found that clinical managers had not entered a Category I PRF into the record. The patient did have a Category II advisory, indicating that the patient was at high risk for recidivism. Because the patient did not have a Category I PRF, providers would not be alerted to the patient's potential for suicide. Clinical managers added a notation of suicide risk to the Category II PRF while we were onsite. However, this still did not meet the requirement of the VHA directive.

Additionally, neither the VISN's nor the facility's policies governing violent behavior adequately addressed appropriate medical record flagging for patients at risk for suicide. The VISN policy did not address suicidal behavior, and the facility policy did not require a Category I advisory for patients at risk for suicide.

Medical Emergency Response Data. The first responders to medical emergencies at the medical center are VA firefighters, who are trained as emergency medical technicians and certified in Basic Life Support (BLS) techniques. Because the medical center had no acute medical beds, patients requiring emergency services or medical stabilization were transferred to a community hospital following a 911 call for ambulance support.

The medical center policy governing medical emergency response requires a critique and analysis of the VA Fire Department's response time, as well as 911 community responses. Our review showed that managers did not trend or report performance data according to medical center policy. At the time of the CAP review, the medical center was in the process of revising the policy to ensure that data related to VA Fire Department response times, ambulance response times, and other relevant clinical information would be trended and reported to an appropriate monitoring committee.

Recommendation 1: We recommended that the VISN Director ensure that VISN policies governing violent behavior comply with the VHA directive.

Recommendation 2: We recommended that the VISN Director ensure that that the Medical Center Director requires that patients requiring Category I PRF advisories are flagged appropriately, medical center policies governing violent behavior comply with the VHA directive, and medical emergency data be trended and reported to an appropriate monitoring committee.

The VISN and Medical Center Directors agreed with the findings and recommendations. The VISN Director charged a multidisciplinary team, which includes members from each VISN 2 facility, to change the process for flagging patient records and assure compliance with the VHA directive. Two Network policies will also be changed to reflect the revised process, and medical center policy will align with VISN policies and procedures.

The Directors also reported that the medical center's policy governing emergency medical response would be revised to define specific medical data requiring trending. Data are to be reported to the EOC Committee and the Executive Committee of the Medical Staff. The improvement actions are acceptable, and we will follow up on implementation plans to ensure all actions are completed.

Environment of Care

VHA regulations require that health care facilities provide clean, safe environments in all patient care areas and establish comprehensive EOC programs that fully meet all VHA, Occupational Safety and Health Administration, and Joint Commission standards. To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance.

We inspected patient care areas that included the following:

Adult Day Health Care Unit	Geriatric Psychiatry Unit
Dental Clinic	Nursing Home Care Units
Domiciliary Units	Restorative Care/Assisted Living Unit

Nurse managers expressed satisfaction with the housekeeping staff assigned to their units, and inspected areas were generally clean and well maintained. Facilities Management Service (FMS) managers corrected identified issues, such as discolored ceiling tiles, while we were onsite.

In addition, we interviewed IC personnel and reviewed IC policies, the IC annual report, and employee illness and injury data. We also requested water quality data and reviewed the management of patients with multi-drug resistant organisms. The IC policies and procedures for managing patients with multi-drug resistant organisms were satisfactory. We identified two areas that required management attention.

Conditions Needing Improvement. Managers needed to ensure that Dental Clinic employees monitored and recorded medication refrigerator temperatures and returned outdated medications to the pharmacy. Additionally, managers needed to improve analysis of municipal water quality data.

Medication Refrigerator Monitoring. Refrigerator temperatures must be monitored to ensure the integrity of medications that require refrigeration. We found that Dental

Clinic employees did not consistently record temperatures Monday through Friday, the days the clinic was operational. Additionally, we found two expired medications in the same refrigerator. One medication expired in February 2007 and the other in March 2007. VHA regulations require that medications be checked regularly (at least monthly) for expiration dates and that expired medications be returned to the pharmacy.

Water Quality Data. VHA Directive 2006−007, *Ensuring the Security and Availability of Potable Water at VHA Facilities,* establishes criteria to ensure water supply security. The directive also addresses actions facilities must take to identify vulnerabilities associated with water supply reduction or interruption during disasters or other emergencies and requires biannual testing for water contamination.

The city of Canandaigua supplies municipal water to the medical center, and the facility maintained a 500,000 gallon potable water storage tank. To assess compliance with security measures, we requested verification that the facility conducted a vulnerability assessment of the potable water storage. Additionally, we requested documentation that the facility obtained and reviewed the city's water treatment and testing data to ensure continued potability of the facility's drinking water.

We found that the facility conducted a vulnerability assessment of the water supply as part of the Physical Security Assessment completed in January 2006. However, FMS managers did not have documentation regarding the treatment and testing of the facility's municipal water supply.

Recommendation 3: We recommended that the VISN Director ensure that the Medical Center Director requires that Dental Service employees monitor refrigerators for adequate temperature control and expired medications and that FMS managers obtain and analyze municipal water quality data according to VHA regulations.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that the Medical VA Care Line Manager implemented a monthly oversight process for refrigerator temperature documentation and medication date checks in Dental Service. Results will be reported to Senior Leadership through quarterly Medical Care Line Reports. The Directors also reported that Engineering Services managers would obtain and analyze city municipal water quality data every 6 months. The improvement actions are acceptable, and we will follow up on implementation plans to ensure the actions are completed.

Computerized Patient Record System Business Rules

Condition Needing Improvement. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, includes the electronic medical record and the paper record. It is also known as the legal health record. The medical record includes items, such as physician orders, patient progress notes, and

examination and test results. Once authors sign their medical record notes, the notes must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes. The added entries must accurately reflect the times and dates they were entered into the medical record.

A communication (software informational patch USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers. It addressed a number of issues related to the editing of electronically signed documents in the Veterans Integrated Health Systems Technology and Architecture system. The OI cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum to all VISN Directors, requiring that all VA medical centers comply with the informational patch sent in October 2004.

CPRS business rules define what functions certain groups or individuals are allowed to perform in the medical record. The OI recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center's Privacy Officer or Chief of Health Information Management Service.

VISN 2 Clinical Application Coordinators (CACs) control CPRS business rules for every facility within the VISN's jurisdiction. We interviewed medical center Information Resource Management Service employees and VISN 2's lead CAC. We found that the VISN had seven business rules that allowed editing of signed notes by users other than the original authors. VISN employees took action to remove these business rules while we were onsite.

Recommendation 4: We recommended that the VISN Director require that VISN CACs review CPRS business rules at least annually to ensure compliance with VHA regulations.

The VISN and Medical Center Directors agreed with the finding and recommendation. Managers deleted the seven business rules. Additionally, managers agreed to review CPRS business rules annually to ensure compliance with VHA regulations. The improvement actions are acceptable, and this recommendation is closed, as implemented.

Other Areas Reviewed

Community Based Outpatient Clinics

The purpose of this review was to evaluate CBOC compliance with VHA regulations regarding selected standards of operation, such as services provided, patient safety, credentialing and privileging, and provision of emergency care. The review also assessed whether the CBOC improved timely access to health care services.

We visited the Rochester CBOC and interviewed primary care service line employees at the medical center and at the CBOC. We reviewed documents related to the CBOC's description of services, specifically, the management of patients taking warfarin (an anti-coagulant medication). We also reviewed documentation related to credentialing and privileging for three CBOC clinicians and background investigations for five CBOC employees. We inspected the clinic's EOC and interviewed 10 CBOC patients.

Clinicians appropriately managed patients receiving warfarin. The three credentialing and privileging files were in order, and we verified that physicians and nurses maintained current licenses. We reviewed documentation to support that managers completed background investigations for the five CBOC employees.

The CBOC was clean and well maintained. Veterans received services in surroundings that safeguarded their privacy, and medical records were stored securely. The emergency management plan was current, clinical staff members were knowledgeable about providing emergency care, and clinicians were trained in BLS techniques. CBOC managers inspected the automated external defibrillator and kept documentation of the inspections current. Patient interviews indicated high levels of satisfaction with staff courtesy and the quality and timeliness of CBOC services, including mental health services. We made no recommendations.

Survey of Healthcare Experiences of Patients

The SHEP, designed to promote improvement strategies that address patient defined needs and concerns, assesses patient experiences with inpatient and outpatient care services during a specified timeframe.

The VHA Executive Career Field Performance Plan for FY 2007 established the target goals. The expectation of the performance plan is that 76 percent of patients responding to the inpatient survey will rate their overall satisfaction as "very good" or excellent." Similarly, 77 percent of patients responding to the outpatient care survey will rate their overall satisfaction as "very good" or "excellent."

We reviewed the medical center's SHEP results and compared them with the national and VISN results. We reviewed the outpatient SHEP score results from the first quarter of FY 2007 (see table on next page) and found that the medical center did not have a satisfactory score in the area of education and information. There were no inpatient results due to a low return response rate of the questionnaires.

Canandaigua VA Medical Center Outpatient SHEP Results Quarter 1, FY 2007	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	81	77.8	94.9+	72.7	83.5	75.7	82	65.3	82	81.1	84.8
VISN	86.8	77.8	97.2+	73.9	84.3	76.7	84.1	74.2	82.9	79.3	87.5
Outpatient Clinics – Overall	87.6	76.9	97.4+	67.6	81.3	77.4	78.9	78.9	79.2	80.2	85.4

+Significantly better than the national average

Managers analyzed the scores and provided documentation of improvement strategies. The strategies included Quick Cards, which measure patients' satisfaction at the point of service; a virtual health desk; an employee goal-sharing program; patient information pamphlets; and a customer service class for employees. A Customer Service Council supported customer service improvement initiatives. Additionally, managers monitored the efficacy of the improvement strategies and communicated the results to staff. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 11, 2007

From: Director, VA Healthcare Network Upstate New York (10N2)

Subject: CAP Review of the Canandaigua VA Medical Center, Canandaigua, New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. Attached is the response from the VA Medical Center Canandaigua, New York, to the draft report from the Combined Assessment Program Review conducted at that facility April 23-27, 2007.

2. The medical center carefully reviewed all items identified as opportunities for improvement and has concurred in all the recommendations that were made. The Network concurs with the recommendations contained in the report.

3. If you have any questions, or need additional information, please contact Douglas Nather, Performance Manager, at (585) 393-7559.

(original signed by:)

Stephen L. Lemons, Ed.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 9, 2007

From: Director, Canandaigua VA Medical Center (532/00)

Subject: CAP Review of the Canandaigua VA Medical Center, Canandaigua, New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. The Department of Veterans Affairs Medical Center at Canandaigua, New York, and its Community Based Outpatient Clinic located in Rochester, New York, were inspected by the Office of Inspector General's CAP Review Team from April 23 through April 27, 2007. The inspection was conducted in a thorough and professional manner.

2. After reviewing the draft IG/CAP Review Report, VAMC Canandaigua concurs with the CAP Review Team's findings. The corrective actions and their target dates for completion are set forth in the action plans.

3. If you have any questions, or need additional information, please contact Douglas Nather, Performance Manager, at (585) 393-7559.

(original signed by:)
Craig S. Howard

Director's 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

Recommendation 1. We recommended that the VISN Director ensure that VISN policies governing violent behavior comply with the VHA directive.

Recommendation 2. We recommended that the VISN Director ensure that that the Medical Center Director requires that patients requiring Category I PRF advisories are flagged appropriately, medical center policies governing violent behavior comply with the VHA directive, and medical emergency data be trended and reported to an appropriate monitoring committee.

Concur **Target Completion Date:** July 6, 2007

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendations regarding the appropriate flagging of patients requiring I PRF advisories. The VISN 2 Director has charged a multidisciplinary team that includes members from across all sites in the network to implement actions that will effectively address the issues identified above. This will involve not only changing the process for the appropriate flagging of patient records to assure compliance with the VHA directive, it will require changes to two Network policies as well, including Management of Disruptive, Threatening, or Violent Behavior and Network 2 Follow-Up Procedures for Behavioral Health At-Risk Outpatients Who Fail to Report for Appointments. Additionally, the Network Director has charged the team with developing a network policy addressing the Management of Patients At Risk for Suicide.

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendations. Please refer to above, as the Medical Center will participate in the development of and, once approved, adopt/align with the VISN 2 Policy and Procedures described in the action plan. Target date for completion is July 6, 2007.

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendations regarding the lack of Emergency Medical Data. The Medical Center Policy on Emergency Medical Response is currently undergoing revision by the facility's Fire Department in collaboration with Medical VA Care Line and will define the specific medical response data to be included, such as the number/types/locations of medical emergencies, the VA Fire Department's response time, the 911 ambulance service's response time, equipment used and its effectiveness/failure, disposition of victim, and a narrative analysis of trends/opportunities for improvement. The Medical Center's Fire Department will collect the data related to VA Fire Department response times, ambulance response times, and other relevant clinical information regarding medical emergency responses and report them monthly to the Environment of Care Committee as well as the Executive Committee of the Medical Staff. Target date for completion June 30, 2007.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that Dental Service employees monitor refrigerators for adequate temperature control and expired medications and that FMS managers obtain and analyze municipal water quality data according to VHA regulations.

Concur **Target Completion Date:** June 30, 2007

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendations regarding the monitoring of refrigerators for temperature control and expired meds in Dental Service. The Medical VA Care Line manager has already implemented a monthly oversight monitoring process to ensure that the medication refrigerator temperature checks and medication date checks within the Dental Service are done on a daily basis according to Medical Center Policy. Monthly results will be reported to Senior Leadership through the quarterly Medical Care Line report. These actions were completed by April 30, 2007.

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendations regarding municipal water supply quality data. Engineering Service will obtain and analyze Canandaigua Municipal Water Quality data for the Medical Center every 6 months or more frequently, as appropriate, in accordance with VHA Directive 2006-007, entitled Ensuring the Security and Availability of Potable Water at VHA Facilities, paragraph 4.e.(3)., dated February 6, 2006. Target date for completion is June 30, 2007.

Recommendation 4. We recommended that the VISN Director require that VISN CACs review CPRS business rules at least annually to ensure compliance with VHA regulations.

Concur **Target Completion Date:** April 25, 2007

The VISN 2 Director and Canandaigua Medical Center Director agree with the findings and recommendation. The OIG/CAP onsite inspector identified seven CPRS TIU business rules that should be removed by Network 2. As a reference, the specific rules identified are:

*Provisional Gross Anatomical-Medical Records Technician

*Provisional Gross Anatomical-Medical Technician

*Provisional Gross Anatomical/Medical Technologist

*Provisional Gross Anatomical-Pathologist or Expected Cosigner

*Surgical H&P/Risk Assessment Author-Dictator

*Clinical Procedures-Author/Dictator

*Autopsy-Pathologist

All of these rules were immediately removed on April 25, 2007, as the inspection was underway. As business rules exist only at the Network level in Network 2, these removals will now effect all facilities. Looking ahead, Network 2 Clinical Application Coordinators (CACs), Network 2 HIMS Manager, and the Network 2 Health Information Council/Electronic Medical Record Committee will systematically review the CPRS business rules on an annual basis to ensure compliance with VHA regulations

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, MSN Director, Boston Office of Healthcare Inspections (781) 687-2317
Acknowledgments	Annette Acosta, MN, FNP, RN Jeanne Martin, Pharm D Sunil Sen-Gupta, PhD, MPH

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 2 (10N2)
Director, Canandaigua VA Medical Center, (532/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Hillary Rodham Clinton, Charles E. Schumer
U.S. House of Representatives: John R. Kuhl, Jr.

This report is available at http://www.va.gov/oig/publications/reports-list.asp.