Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, Nevada

Report No. 06-03484-96 **March 14, 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 is 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.

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Executive Summary

Introduction

During the week of October 30–November 2, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Sierra Nevada Health Care System (the health care system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management. During the review, we also provided fraud and integrity awareness training to 72 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 21.

Results of Review

The CAP review covered eight operational activities. We identified the following three organizational strengths and reported accomplishments:

- Interdisciplinary efforts resulted in improved medication reconciliation across the health care system.
- An interdisciplinary team addressed medication delivery problems and made several significant improvements.
- The Contract Community Nursing Home Program (CNH) provided excellent oversight of veterans placed in contract nursing homes.

We made recommendations in four of the activities reviewed. For these activities, the health care system needed to:

- Implement a systematic medical record quality review program and address patient complaint trends with appropriate actions.
- Take effective actions to meet the breast cancer screening performance measure.
- Ensure that the informed consent process for cardiac catheterization procedures includes all required elements.
- Take actions to scan all non-VA care documentation into the VA computer system, resolve telephone access problems, and address fire safety concerns at the Minden, NV, community based outpatient clinic.

The health care system complied with selected standards in the following three activities:

- Patient satisfaction survey results action plans.

- Monitoring patients on atypical antipsychotic medications.
- Environment of care.

This report was prepared under the direction of Ms. Julie Watrous, Director, Los Angeles Healthcare Inspections Division.

Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Health Care System Profile

Organization. The VA Sierra Nevada Health Care System (the health care system) is a tertiary care facility in Reno, NV, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics (CBOCs) in Auburn, California, and Minden, Nevada. The health care system is part of Veterans Integrated Service Network (VISN) 21 and serves a veteran population of about 116,175 in a primary service area that includes 12 counties in Nevada and 10 counties in California.

Programs. The health care system provides primary care, medical, surgical, mental health, geriatric, and rehabilitation services. The health care system has 56 hospital beds and 60 nursing home beds.

Affiliations and Research. The health care system is affiliated with the University of Nevada School of Medicine and supports 30 medical resident positions in 3 training programs. Other affiliations include the East Bay Surgical Program at the University of California, San Francisco. In fiscal year (FY) 2005, the health care system research program had 49 projects and a budget of $1.2 million. Important areas of research include adult stem cell, cardiovascular disease, and oncology.

Resources. In FY 2005, the health care system's expenditures totaled $73.6 million. The FY 2006 medical care budget was $86.3 million. Staffing in FY 2006 was 764 full-time equivalent employees (FTE), including 52 physician and 241 nursing FTE.

Workload. In FY 2006, the health care system treated 25,005 unique patients and provided 14,519 inpatient days in the hospital and 20,078 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 2,858 discharges, and the average daily census, including nursing home patients, was 95. Outpatient workload totaled 244,087 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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and quality management (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 clinical and administrative 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 care to identify and correct harmful and potentially harmful practices and conditions.

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

- Breast Cancer Management
- Cardiac Catheterization Laboratory
- CBOC
- CNH Program
- Environment of Care
- Monitoring Patients on Atypical Antipsychotic Medications
- Patient Satisfaction Survey Scores
- QM

The review covered facility operations for FYs 2005 and 2006 and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strengths and Reported Accomplishments

Interdisciplinary Efforts Resulted in Improved Medication Reconciliation.

The medical literature suggests that up to 50 percent of all medication errors and 20 percent of adverse events are due to poor communication of medical information at different transition points during hospitalization. Medication reconciliation is a process designed to help prevent medication errors at different transition points during hospitalization. The health care system chartered an interdisciplinary team to develop and implement a process to ensure that all medications are completely and accurately reconciled across the continuum of care. The team created electronic progress notes for admission, transfer, and discharge. These notes serve as tools to assist providers in appropriately documenting medication reconciliation. The new process was implemented in January 2006. By September 2006, medication reconciliation had improved by more than 75 percent.

"Troubleshooters" Team Acted Promptly on Medication Delivery Problems.

The health care system chartered an interdisciplinary team, consisting of representatives from pharmacy, nursing, information management, and patient safety to improve medication delivery system safety. This team meets twice a month to analyze, repair, simplify, and improve medication safety. For example, this team addressed an identified problem in heparin administration. Heparin is an anticoagulant which prevents the formation of blood clots. In late 2003, providers made four errors in heparin order entry into the computerized patient record system (CPRS). The team created a heparin order protocol and provided training in its use, resulting in only one heparin order entry error since January 2004. Another example was fixing insulin dosing on intravenous (IV) pumps. In early 2005, two cases where excess insulin was infused were due to double input error. The team worked with biomedical engineers to pre-set dedicated IV pumps for insulin infusion with maximum dosage limits. No additional incidents have occurred.

CNH Program Provided Excellent Oversight.

We found that the health care system's CNH program was comprehensive and well organized and that the CNH Oversight Committee and review team provided excellent controls over the functions of the program. The CNH review team completed initial and annual reviews of each contract facility. The CNH Coordinator and nurse developed collaborative relationships with nursing home administrative and clinical teams and monitored the care provided to veteran residents on a monthly basis. Additionally, the CNH Coordinator established contacts with representatives from the State ombudsman's office and Veteran's Benefits Office, in accordance with Veterans Health Administration (VHA) regulations.

Opportunities for Improvement

Quality Management

The purpose of this review was to evaluate whether the health care system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the health care system Director, Chief of Staff, Chief Nurse Executive, and QM personnel; and we evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care in the health care system. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, we identified two program areas that needed improvement.

Systematic Medical Record Reviews. Clinicians had reviewed samples of medical records to assess the presence and thoroughness of some items, such as progress notes and pain assessments. However, there was no systematic review process in place for other required items, such as informed consents and problem lists. VHA directives and accreditation standards require that facilities have a systematic medical record quality review process covering all required items with data analysis and actions taken to address areas where performance is below expectations.

Addressing Patient Complaints Trends. Although patient complaints were analyzed and reports were presented at the Quality Council, the summary recommendations were not addressed by the council, and the actions were not implemented. For example, the Patient Advocate identified a trend in complaints about the pain clinic and made recommendations for improvement in a report presented at the May Quality Council meeting and again in the subsequent report presented at the August meeting. However, the only notation in both meetings' minutes was "report accepted." VHA policy and accreditation standards require that identified trends in patient complaints be addressed and acted upon, as appropriate.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director requires that (a) the Health Information Manager coordinates a comprehensive medical record review process that meets all applicable requirements and (b) recommendations made by the Patient Advocate be addressed and acted upon, as appropriate.

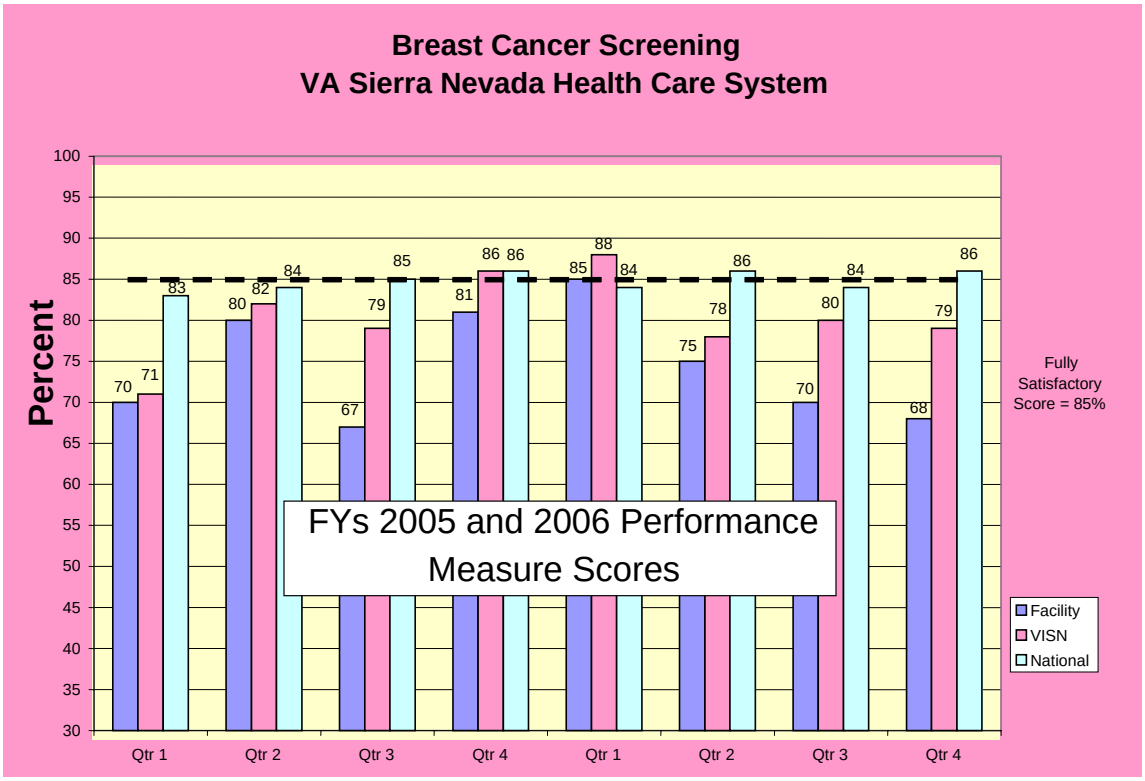
The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they will take actions, which will include establishing a medical record review process and assigning the Veterans Relations Committee to address patient complaints trends. The target date for completion is January 8, 2007.

The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management

The purpose of this review was to assess the effectiveness of breast cancer screening and management of abnormal mammogram results. We evaluated the health care system's scores for the breast cancer screening performance measure in FYs 2005 and 2006, interviewed program managers, reviewed medical records, and analyzed relevant documents. In FYs 2005 and 2006, the health care system performed a total of 374 mammograms.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The health care system achieved a fully satisfactory score of 85 percent in only 1 quarter during FYs 2005 and 2006. All screening and diagnostic mammograms were provided at community facilities on a fee-for-service basis.



Program managers told us that because patients had the option to obtain mammograms at six non-VA facilities, it was difficult to track mammogram activities from multiple sites. In July 2006, managers signed an interim contract with Reno Radiological to provide

mammograms for the majority of the health care system's patients, and results are expected to improve.

For patients with abnormal mammogram results, timely diagnosis and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in all 10 patients who had abnormal mammograms during FYs 2005 and 2006. In all 10 cases, we found that patients received appropriate screening, timely notifications of test results, and timely follow-up services. Four patients who had malignant diagnoses had timely consultations.

Patients appropriately screened	Mammography results reported to patients within 30 days	Patients received timely biopsy procedure	Patients appropriately notified of their diagnoses	Patients received timely consultations
10/10	**10/10**	**10/10**	**10/10**	**4/4**

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Health Care System Director takes appropriate actions to improve compliance with VHA's breast cancer screening performance measure.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they will take actions, which will include extending the interim mammography contract, generating a monthly report listing women due for mammograms, and monitoring whether the mammography reports get into the medical records. The target date for completion is March 1, 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Cardiac Catheterization Laboratory

The purpose of this review was to determine if the health care system's cardiac catheterization laboratory practices were consistent with VHA policy and applicable standards.[1] The health care system's cardiac catheterization laboratory clinicians had completed a sufficient volume of procedures to indicate competence, employees had appropriate credentials and certifications, and complication rates were below expected averages. However, the health care system needed to improve the documentation of informed consents for cardiac catheterization procedures.

We reviewed the medical records of 10 patients who underwent a cardiac catheterization procedure in FY 2005. While it was clear that the clinicians provided relevant information to all the patients, the informed consent documentation did not contain all elements required in VHA policy. Specifically, both descriptions of the procedures to be

[1] American College of Cardiology/Society for Cardiac Angiography and Interventions, *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards*, 2001. These standards define parameters, including provider procedure volumes, the informed consent process, and cardiopulmonary resuscitation training.

performed and all major risks, such as the possibility of emergency bypass surgery, need to be added.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director requires that informed consents used in the cardiac catheterization laboratory include all required elements.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they implemented the use of the automated consent form for all cardiac catheterizations, which includes all required elements. They also implemented a monitoring process to ensure proper utilization. The improvement actions are acceptable, and we consider the recommendation closed.

Community Based Outpatient Clinic

The purpose of this review was to determine if the Carson Valley CBOC in Minden, Nevada, complied with selected VHA standards of CBOC operation, improved patient access to health care services, and maintained the same standards of care for anticoagulant therapy as the health care system's Reno hospital facility. We conducted environmental rounds; interviewed key personnel and patients; and evaluated policies, procedures, and other relevant documents.

The CBOC generally provided high quality care that improved access, timeliness, and convenience of services. Patients were satisfied with all aspects of care received, and the clinic was compliant with most of the VHA standards of operation reviewed. The standards of care for providing anticoagulant therapy were comparable at the CBOC and Reno facility. However, we identified three areas that needed improvement.

Patient Medical Information. Maximum utilization of electronic medical records was hindered at this CBOC because there was no mechanism to scan paper documents into CPRS. For example, when patients received care from non-VA facilities, documents such as progress notes, consult reports, and test results were frequently submitted to the CBOC but were stored in hard copy files. Retrieval of such data was time consuming and inaccessible to remote CPRS users.

Telephone Access. Nine of the 10 patients we interviewed stated that they had registered complaints regarding their inability to contact CBOC personnel because of telephone problems, such as disconnections, unanswered calls, and busy signals. We noted several documented actions taken that were intended to improve the phone system, but problems apparently continued.

Fire Alarms. We found that, although the CBOC had smoke detectors, it did not have any fire alarms that could be manually activated if a fire was detected. The CBOC is located on the second floor of a leased building. Also, although the first floor of the

building did have manual activation alarms and smoke detectors, there was no notification system installed on the second floor, and the first floor alarm sound could not be heard in the CBOC, as evidenced by prior drills. This situation causes safety concerns for patients and employees.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Health Care System Director takes actions to: (a) ensure that pertinent clinical data from patient care received at non-VA facilities be scanned into CPRS, (b) resolve telephone issues that impede patient access and satisfaction, and (c) address safety concerns related to manual fire alarms and audible alarm sounds.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they implemented a process in which all pertinent hard-copy clinical data is sent to the Reno facility for scanning into CPRS. They will also take actions, which will include obtaining a scanner for the CBOC, implementing a call center, and installing pull fire alarms and an audible alarm at the CBOC. The target date for completion is April 15, 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Review Topics

Environment of Care

The purpose of the evaluation was to determine if the health care system maintained a safe and clean patient care environment. We inspected clinical and non-clinical areas for cleanliness, safety, privacy, and general maintenance. The health care system generally maintained a clean and safe environment.

Patient Satisfaction Survey Results Action Plans

The purpose of this review was to assess the extent to which the health care system used the results of VHA's patient satisfaction survey to improve care, treatment, and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit healthcare surveying group. VHA set 76 percent of patient satisfaction scores of very good or excellent for inpatients and 77 percent for outpatients as the FY 2006 target for the results of its Survey of the Health Experiences of Patients (SHEP). The table below shows the national, VISN 21, and the health care system's survey results.

VA Sierra Nevada Health Care System

INPATIENT SHEP RESULTS

FY 2006 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**81.31**	**78.63**	**89.95**	**68.02**	**65.8**	**75.85**	**83.41**	**74.49**	**70.03**
VISN	**82.6+**	**79.4**	**90.9+**	**68.10**	**66.80**	**78.1+**	**85.2+**	**74.4**	**71.3+**
Health Care System	83.30+	79.40	91.90+	69.70	68.10	75.90	87.0+	75.70	71.70

OUTPATIENT SHEP RESULTS

FY 2006 Quarter 3	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**80.9**	**77**	**94.6**	**72**	**83**	**75.1**	**81.1**	**64.4**	**81.3**	**80.5**	**84.1**
VISN	**82.3**	**76.2**	**94.7**	**72**	**82.3**	**74.7**	**84.6**	**72.1**	**81.1**	**81**	**82.5**
Health Care System Clinics	82.4	85	92.7	75.3	84.1	76.2	80.9	65	81.8	84	81

Legend: "+" Indicates Results that are Significantly Better than the National Average

The health care system's managers shared the results with employees, as expected. Managers had implemented action plans to improve patient satisfaction with education and information, emotional support, pharmacy pick-up, and overall coordination. We found the action plans acceptable and did not make any recommendations.

Monitoring Patients on Atypical Antipsychotic Medications

The purpose of this review was to determine whether clinicians appropriately monitored and managed patients receiving a specific class of medications used to treat psychosis. While these medications cause fewer neurological side effects (such as involuntary tremors) than other classes of antipsychotic medications, they increase the risk of developing diabetes. In FY 2004, the health care system had implemented the use of a progress note template that included baseline monitoring parameters for all patients receiving atypical antipsychotic medications.

We reviewed the medical records of 13 randomly selected patients who were receiving 1 or more atypical antipsychotic medications for at least 90 days in FY 2005. One of the 13 patients had diabetes. We found that all of the 12 non-diabetic patients were screened for diabetes and appropriately counseled about prevention strategies.

VHA clinical practice guidelines for the management of diabetes suggest that low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). The fully satisfactory performance measure target is for 75 percent of patients to have LDL-C values of less than 120 mg/dl. Although the health care system met the performance measure target in only 1 of the last 4 quarters, clinical managers had implemented acceptable corrective actions. We did not make any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 22, 2006

From: VISN Director, VA Sierra Pacific Network (10N21)

Subj: **Combined Assessment Program Review of the VA Sierra Nevada Health Care System**

To: Director, VHA Management Review Office (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the VA Sierra Nevada Health Care System, Reno, Nevada.

2. If you have any questions regarding this report, please contact Mary Powers, Chief, Quality Management, at (775) 328-1709 or Judy Daley at (775) 328-1774.

(original signed by
Cassandra M. Law for:)
Robert L. Wiebe, M.D.
Attachments

Health Care System Director Comments
VA Sierra Nevada Health Care System - Reno, Nevada

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Quality Management – Systematic Medical Record Reviews and Addressing Patient Complaint Trends

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the Health Information Manager coordinates a comprehensive medical record review process that meets all applicable requirements and (b) recommendations made by the Patient Advocate be addressed and acted upon, as appropriate.

Concur with recommended improvement actions.

a. Health Information Manager coordinates a comprehensive medical record review process that meets all applicable requirements

Planned Action: The Health Information Manager is establishing a process to review medical records based upon hospital-defined indicators which address the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the medical record. Process to be implemented by **January 8, 2007**.

b. Recommendations made by the Patient Advocate be addressed and acted upon, as appropriate

Planned Action: The quarterly Patient Representative Report will continue to be reported to the Veterans Relations Committee. Effective **November 28, 2006**, the Veterans Relations Committee will address and take action on identified trends in patient complaints identified in the Patient Representative Report. The action and follow-up will be documented in the Veterans Relations Committee meeting minutes.

2. Breast Cancer Management – Compliance with VHA's Breast Cancer Screening Performance Measure

Recommended Improvement Action 2. We recommend that the VISN Director ensures that the Health Care System Director takes appropriate actions to improve compliance with VHA's breast cancer screening performance measure.

Concur with recommended improvement action.

a. **Appropriate actions taken to improve compliance with VHA's breast cancer screening performance measure.**

Planned Action: A Women's Health Program Coordinator was appointed in May 2006. In July 2006, an interim contract was signed with Reno Radiological to provide mammograms for a majority of the health care system's patients, providing ease of results tracking. The contracting officer has extended the interim contract to **February 28, 2007**, with the final contract to be awarded **March 1, 2007**. A monthly report by provider will be generated listing the women veterans due for mammograms each month, as well as in the next 3 months. Internally, there is a monitoring process in place to determine if reports are getting into the medical record. External monitoring will be via EPRP.

3. Cardiac Catheterization Laboratory – Informed Consent Elements

Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Health Care System Director requires that informed consents used in the cardiac catheterization laboratory include all required elements.

Concur with recommended improvement actions.

a. Informed consents used in the cardiac catheterization laboratory include all required elements

Planned Action: The electronic iMed™ Consent form is being utilized for all cardiac catheterizations. This replaces the previously utilized printed cardiac catheterization consent form. All required elements are included in the iMed™ Consent. Consents will be monitored to ensure the iMed™ Consent process is consistently utilized.

4. CBOC – Patient Medical Information, Telephone Access and Fire Alarms

Recommended Improvement Action 4. We recommend that the VISN Director ensures that the Health Care System Director takes actions to (a) ensure that pertinent clinical data from patient care received at non-VA facilities be scanned into CPRS, (b) resolve telephone issues that impede patient access and satisfaction, and (c) address safety concerns related to manual fire alarms and audible alarm sounds.

Concur with recommended improvement actions.

a. Ensure that pertinent clinical data from patient care received at non-VA facilities be scanned into CPRS:

Planned Action: All pertinent clinical data from non-VA facilities for Minden CBOC patients will be sent to the VA Sierra Nevada Health Care System main campus in Reno for scanning into CPRS by File Room Staff, effective **November 16, 2006**. In addition, a scanner will be obtained for the Minden CBOC, and staff will be trained in scanning documents by **January 8, 2007.** This will allow staff to scan documents into CPRS

immediately if warranted by the patient's condition, clinical data, and/or provider preference.

b. Resolve telephone issues that impede patient access and satisfaction:

Planned Action: Effective **December 1, 2006**, one staff from the Minden CBOC will be given exclusive responsibility to answer the telephone, and designated back-up staff will be identified. An additional hire of a health technician for telephones is anticipated to be completed by **January 8, 2007**. Ambulatory Care will closely monitor the telephone system for wait times and lost calls to ascertain the effectiveness of dedicated staff answering the phones. Ongoing changes will be made, dependent on the monitoring data, so CBOC patients can access the CBOC via telephone with their health care issues. In addition, a "Call Center" plan has been approved and signed by the Director. A renovation of the call center location is currently underway, and recruitment of a Call Center Supervisor has begun. The Call Center is anticipated to be operational by **April 15, 2007**, and will be available for calls to roll over from Minden as a backup.

c. Address safety concerns related to manual fire alarms and audible alarm sounds:

Planned Action: Although the VA Sierra Nevada Health Care System CBOC in Minden currently meets all life safety codes for business occupancy, we concur with the recommendation to improve life safety aspects of the CBOC for patients and staff. VA Sierra Nevada Health Care System is currently working with contracting and the local fire marshal to improve the fire alarm system. Two pull stations will be installed at exit doors, and an audible alarm system for upstairs (where the CBOC is located) will be tied into the existing building alarm system. This will be completed by **March 1, 2007**.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, RN, Director Los Angeles Healthcare Inspections Division (213) 253-5134
Acknowledgments	Daisy Arugay Michelle Porter Michael Seitler John Tryboski

Appendix D

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