Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02564-163

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

July 13, 2009

Washington, DC 20420

Why We Did This Review

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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Table of Contents

Executive Summary

Introduction

During the week of May 18–22, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Syracuse VA Medical Center (the medical center), Syracuse, NY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training for 129 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 2.

Results of the Review

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

- Improved patient flow through the emergency department (ED).
- Improved access to primary care.
- Improved operating room (OR) efficiency.

We made recommendations in five of the activities reviewed. For these activities, medical center managers needed to:

- Collect and analyze provider performance data and utilize the information to support reprivileging decisions.
- Consistently assess adverse events to identify events that require disclosure.
- Require that inter-facility transfer documentation be available timely in the computerized patient record system (CPRS).
- Ensure documentation of pain medication effectiveness within the required timeframes and monitor compliance.
- Improve medical record documentation for patients deemed at high risk for suicide and monitor compliance.
- Ensure that contracted/agency registered nurses (RNs) have current mandatory training.

The medical center complied with selected standards in the following three activities:

- Coordination of Care.
- Environment of Care (EOC).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Jeanne Martin, Associate Director, Bedford Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–16 for 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

Profile

Organization. The medical center is a tertiary care facility located in Syracuse, NY, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at eight community based outpatient clinics (CBOCs) in Massena, Carthage, Cortland, Ithaca, Auburn, Oswego, Binghamton, and Rome, NY. The medical center is part of VISN 2 and serves a veteran population of approximately 190,000 throughout central New York.

Programs. The medical center provides comprehensive health care through primary care, acute care (medicine, surgery, and psychiatry), and long-term care services. Additionally, it provides services in physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

Affiliations and Research. The medical center is affiliated with the State University of New York Upstate Medical University and provides training for more than 400 residents. It also provides training in other health care professions, such as nursing, pharmacy, physical therapy, occupational therapy, psychology, and social work.

In fiscal year (FY) 2008, the medical center's research program had 120 projects and a budget of over $1 million. Important areas of research included neuroscience projects, studies on tuberculosis, molecular investigations of arteriosclerosis, and molecular genetic studies in multiple sclerosis. Additionally, the medical center conducts clinical trials in hematology and oncology and in metabolic, cardiovascular, and pulmonary disorders.

Resources. In FY 2008, medical care expenditures totaled $207 million. FY 2008 staffing was 1,285 full-time employee equivalents (FTE), including 95 physician and 381 nursing FTE.

Workload. In FY 2008, the medical center treated more than 39,000 unique patients and provided over 31,600 inpatient days in the hospital and over 15,000 inpatient days in the community living center (CLC).[1] The inpatient care workload totaled 4,239 discharges, and

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

the average daily census, including CLC patients, was 132. Outpatient workload totaled more than 313,600 visits.

Objectives and Scope

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 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and quarter 1 of FY 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the Syracuse VA Medical Center,*

Syracuse, New York, Report No. 06-01218-176, July 26, 2006). In that report, we identified an improvement opportunity in breast cancer management. During our follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the recommendation, and we consider the issue closed.

During this review, we also presented fraud and integrity awareness briefings for 129 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Improved Patient Flow Through the Emergency Department

Managers developed a computerized patient tracking system for the ED that improved patient flow. The system, which is interactive with CPRS, allows for real-time documentation of patient care activities and also provides comprehensive reports on the delivery of care. This has led to improvement in the delivery of timely care, better allocation of ED resources, and improvement in assessments of patient flow issues. The system is currently used in approximately 30 Veterans Health Administration (VHA) EDs and is scheduled for national deployment in spring or summer 2009.

Improved Access to Primary Care

Because of unacceptable wait times for new patients trying to obtain clinic appointments, managers moved from a decentralized scheduling process to a centralized patient scheduling system with oversight by the Business Office. After implementation of this system, primary care clinics showed a 40 percent increase in the number of new patients receiving appointments within 30 days (a VHA performance measure).

Improved Operating Room Efficiency

Surgery Service managers developed a web-based OR scheduling calendar that allows clinicians to input all information needed to schedule cases and request support services and special needs, such as equipment, implants, or

instruments. The calendar can be accessed at any time and has improved communication with the intensive care unit, the pharmacy, radiology, and other support services that are important for optimal patient outcomes. This initiative has also improved surgery start times and pre-operative, peri-operative, and post-operative efficiency. The medical center was recognized nationally by VHA for this initiative and has had numerous requests for the calendar from other VHA facilities.

Results

Review Activities With Recommendations

Quality Management Program

The purposes of this review were to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified two areas that needed improvement.

Provider Performance Monitoring. VHA regulations[2] require that clinical managers develop plans for continuous performance monitoring for the medical staff. According to the requirements, performance data should be ongoing, include indicators for continuing qualifications and competencies, and be reviewed and considered during the reprivileging process.[3] We reviewed credentialing and privileging folders and corresponding PI data for 21 providers reprivileged in the past 12 months and found that 9 (43 percent) of the providers had inadequate or no supporting QM/PI data for the privileges granted.

Adverse Event Disclosure. VHA regulations[4] require that facilities disclose adverse events related to clinical care to patients and/or their families. We reviewed the medical

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[3] The process of evaluating professional credentials and clinical competencies of practitioners who hold clinical privileges at the facility.
[4] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

records of 16 patients who experienced adverse events and found that in 5 (31 percent) of the records, the events met the criteria for adverse event disclosure. However, there was no documentation to support that clinical managers discussed the events with the patients or their families.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize the information to support reprivileging decisions.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently assess adverse events to identify events that require disclosure.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that by August 31, 2009, all physician professional practice evaluation folders will contain provider-specific data to support reprivileging activities. They also reported that a process to identify adverse events that require disclosure will be in place by July 17, 2009. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of E/UC operations, such as clinical services, consults, inter-facility transfers, staffing, and staff competencies. We also inspected the physical environment for cleanliness, safety, and equipment maintenance.

The medical center did not have a UC clinic but did have an ED that operated 7 days a week, 24 hours a day. We reviewed relevant VHA and medical center policies and interviewed the ED medical director and nurse manager. We also interviewed the employees involved in managing transfers. Our review identified no issues with clinical services, consults, staffing, staff competencies, or the EOC. However, we identified one area that needed improvement.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other facilities. VHA[5] and the medical center's local policy require that inter-facility transfer data be available in CPRS. However,

[5] VHA Directive 2007-015, *Inter-facility Transfer Policy*, May 7, 2007.

none of the three records reviewed contained the appropriate transfer information. While we were onsite, ED staff located the hard copy forms containing the required documentation for the three patients; however, since the ED transfers took place approximately 3 months prior to our visit, this information should have been available in CPRS.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that inter-facility transfer documentation be available timely in CPRS.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the inter-facility transfer form is now available electronically and that chart reviews will be implemented to ensure that the form is available in CPRS within 24 hours of patient transfer. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management processes to ensure safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes on the CLC and on inpatient units, and we interviewed nurse managers and other nursing staff. Additionally, we observed nurses administering medications, and we asked patients if nurses scanned their wristbands prior to administering their medications.

We found adequate management of medications brought into the medical center by patients or their families and determined that nurses scanned patients' wristbands prior to medication administration. However, we identified one area that needed improvement.

Pain Medication Reassessment. The medical center's policy governing pain management requires that pain reassessments for PRN[6] oral opiate analgesics occur within 90 minutes of administration. The medical center's Bar Code Medication Administration (BCMA) policy requires documentation of the effectiveness of all PRN medications within 240 minutes (4 hours) of administration. We reviewed 186 administered doses of PRN pain medications for the period of March 8–14, 2009, and found that pain

[6] PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as circumstances require.

reassessments for 98 (53 percent) of the doses were not documented within established timeframes.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires the documentation of PRN pain medication effectiveness within the required timeframes and that nurse managers monitor compliance.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that local policy will be revised to require that pain medication effectiveness be documented within 4 hours of administration. They also reported that the BCMA Coordinator and nurse managers will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented suicide prevention programs that were in compliance with VHA regulations.[7] We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,[8] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[9] documented safety plans that addressed suicidality, and documented collaboration between mental health (MH) providers and SPCs. We also reviewed a sample of providers' training records to determine whether they received the required clinician suicide prevention training.

We found that the suicide prevention program was generally effective. The medical center appointed an SPC who fulfilled all the required functions (there was no very large CBOC). All 10 training records reviewed showed evidence of the required training. However, we identified one area that needed improvement.

Medical Record Documentation. We reviewed the medical records of 10 patients placed on the high risk for suicide list. We found PRFs for all 10 patients. However, we found that

[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[8] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[9] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

7 (70 percent) of the records did not have documented safety plans and that 2 (20 percent) did not show clear evidence of collaboration between the SPC and MH providers.

Additionally, we reviewed minutes from Behavioral Health team leader meetings. The minutes reflected that team leaders had identified the lack of safety plans and suicide risk assessments as issues. Managers had developed safety plan and risk assessment templates to aid clinicians with documentation; however, they were not monitoring compliance with template use.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans and SPC and MH provider collaboration for patients deemed at high risk for suicide and ensures that managers monitor compliance.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the SPC and Behavioral Health will perform chart reviews on all high-risk patients to ensure appropriate documentation. Results will be discussed at MH team leader meetings and reported to the Health Information Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed three files of contracted/agency RNs who worked at the medical center within the past year and identified one area that needed improvement.

Training. VHA requires several training courses for staff as well as for contracted/agency RNs.[10] We found that one contracted/agency RN was allowed to work and maintain computer access even though the required information security and privacy training courses were not current.

[10] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that contracted/agency RNs have current mandatory training.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that managers have developed procedures to ensure that contracted/agency RNs are included in the VA Learning Management System (LMS). LMS allows managers to track mandatory training for all employees, including contracted employees. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purposes of this review were to evaluate whether the medical center's inpatient consultations, intra-facility transfers, and discharges were coordinated appropriately over the continuum of care and whether the medical center was in compliance with VHA directives, local policies, and accreditation standards. Coordinated consultations, transfers, and discharges are essential to integrated care processes and result in optimal patient care outcomes. We found that providers managed patient consults, intra-facility transfers, and discharges appropriately. We made no recommendations.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA facilities are required to establish comprehensive EOC programs that fully meet VHA, Occupational Safety and Health Administration, and accreditation requirements. We inspected the following areas: (a) two medical/surgical units, (b) the intensive care unit, (c) the acute MH unit, (d) the CLC, (e) one primary care clinic, (f) the dental clinic, and (j) the outpatient behavioral health clinic.

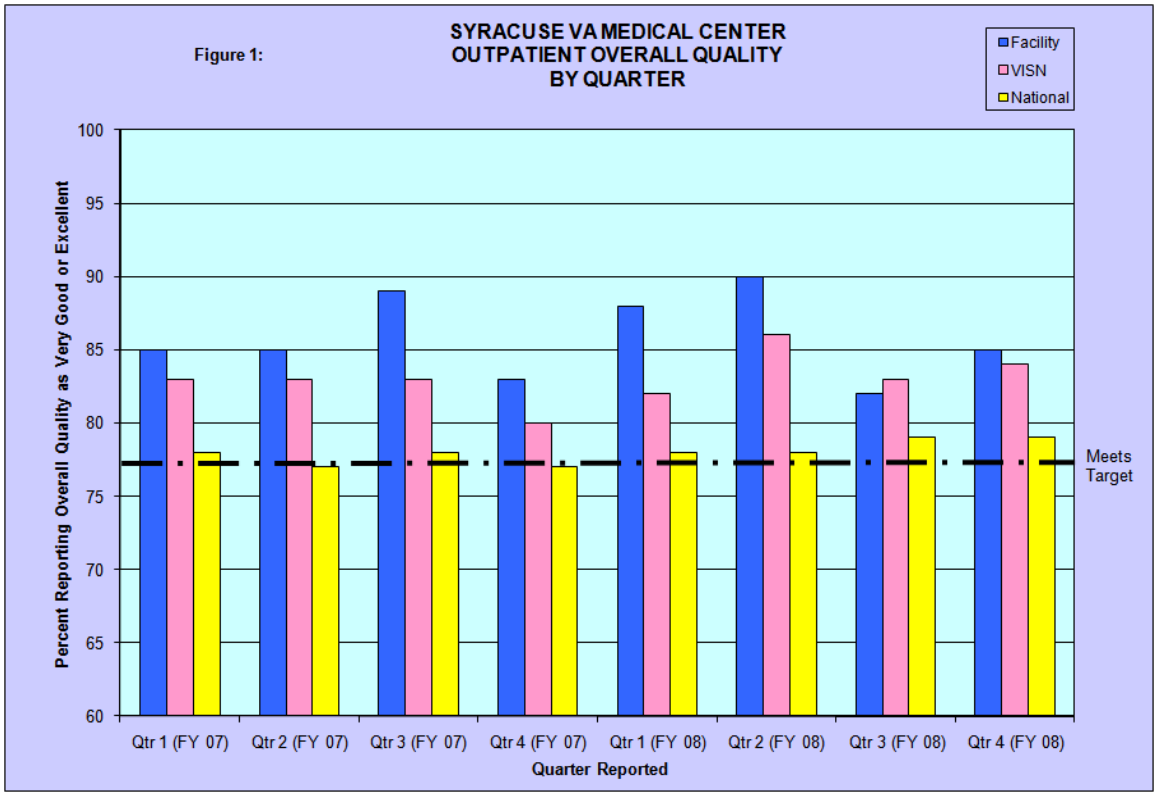
The inspected areas were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their areas. Additionally, we determined that managers identified environmental hazards on the acute MH unit that potentially posed threats to patients. The medical center provided documentation of risk assessment and abatement tracking of safety issues

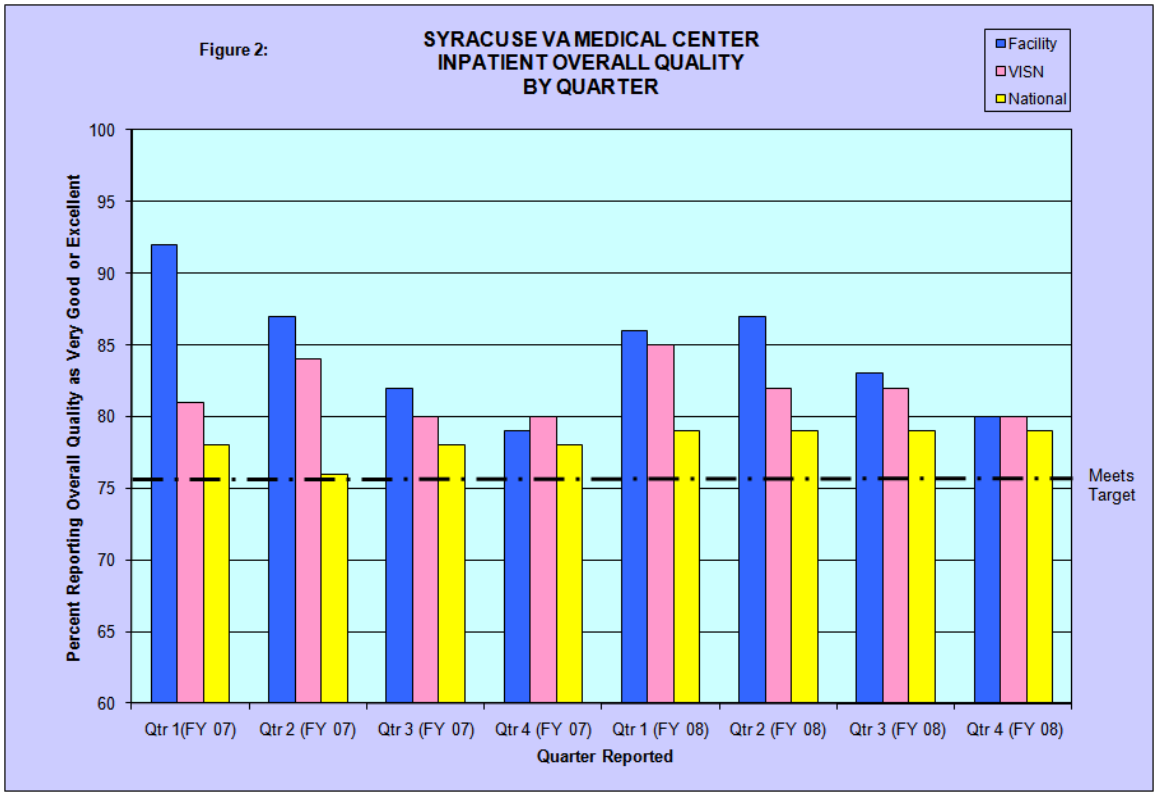
previously identified on the unit, and we found that unit staff completed suicide risk training. We also evaluated the infection control program's management of data and processes in which the data were used to improve performance and found the program satisfactory. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA health care facilities used quarterly or semi-annual SHEP results to improve patient care and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. We reviewed SHEP scores for FYs 2007 and 2008. Figures 1 and 2 below and on the next page show the medical center's patient satisfaction performance measure results for outpatients and inpatients, respectively.

Figure 1:





Outpatient and inpatient scores were above target for all 8 quarters. Manager's analyzed SHEP data, identified service standards for further improvement, developed improvement strategies, and monitored the results of the strategies. Survey results and improvement strategies were distributed throughout the organization. Additionally, effective October 1, 2008, VHA changed to a new SHEP survey process. We reviewed 1st quarter data and noted that the medical center's data met the target scores. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2009

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

Subject: **Combined Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

I have reviewed the findings contained in the subject Combined Assessment Program Review conducted during the week of May 18, 2009. I concur with the facility action plans to resolve the identified findings.

(original signed by:)
Stephen L. Lemons, Ed.D., FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2009

From: Director, Syracuse VA Medical Center (528A7/00)

Subject: **Combined Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

Our review of the findings contained in the subject Combined Assessment Program Review conducted during the week of May 18, 2009, has been completed. We concur with the findings noted therein and submit for your review and approval our actions to resolve the identified recommendations.

(original signed by:)
James Cody
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

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize the information to support reprivileging decisions.

Concur.

Facility Response – As this issue was raised specific to contract and fee basis providers that provide service at the Syracuse VA on an infrequent basis, the Chief of Staff met with University Hospital credentialing and privileging on 5/22/09 and agreed in principle to development of a sharing of information agreement for reprivileging data. The agreement language is currently being reviewed by legal counsel and is pending final approval. The data sharing agreement includes organ specific information, diagnosis, and procedure outcomes. The Syracuse VA Credentials Committee will analyze and utilize provider specific performance data collected through the sharing agreement to support reprivileging decisions. By 8/31/09, all Physician Professional Practice Evaluation (PPPE) folders, including contract and fee basis providers, will contain organ specific information, diagnosis, and procedure outcome data to support reprivileging activities.

Status: In Progress

Target Completion Date: August 31, 2009

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently assess adverse events to identify events that require disclosure.

Concur.

Facility Response – An identifying question will be added to the occurrence screen/adverse event template to ensure providers consistently assess and identify events that require disclosure. Consultation with Regional Counsel and the Chief of Staff will be initiated if a disclosure is required.

Status: In Progress

Target Completion Date: July 17, 2009

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that inter-facility transfer documentation be available timely in CPRS.

Concur.

Facility Response – The facility clinical applications coordinator loaded the electronic inter-facility transfer forms into IMED consent on 6/8/09. Inter-facility transfer documentation will be required to be available in CPRS within 24 hours of transfer. The implementation plan for this recommendation will involve chart review of all patient transfers to ensure that the form is appropriately available in CPRS within 24 hours of transfer.

Status: In Progress

Target Completion Date: July 31, 2009

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires the documentation of PRN pain medication effectiveness within the required timeframes and that nurse managers monitor compliance.

Concur.

Facility Response – On June 9, 2009, the Nurse Executive Committee reviewed the recommendation and is pursuing a redraft of the local facility pain policy to require PRN pain medication effectiveness to be documented in the medical record within 4 hours of administration. The BCMA Coordinator and nurse managers are monitoring PRN effectiveness to ensure compliance.

Status: In Progress

Target Completion Date: July 7, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans and SPC and MH provider collaboration for patients deemed at high risk for suicide and ensures that managers monitor compliance.

Concur.

Facility Response – The Suicide Prevention Coordinator is now performing chart audits on all patients at high risk for suicide to ensure the patient safety plan and suicide risk assessment documentation is in the medical record. This information will be discussed at team leader meetings with the Suicide Prevention Team and mental health providers. Additionally, the facility Health Information Committee will require Behavioral Health to submit medical record reviews on a regular basis to verify that patient safety plan and suicide risk assessment documentation is in the medical record.

Status: In Progress

Target Completion Date: July 31, 2009

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that contracted/agency RNs have current mandatory training.

Concur.

Facility Response – The contract employee was immediately added to the LMS system to track and ensure mandatory privacy and cyber security training is completed annually. Additionally, a plan to ensure that all appropriate individuals are added to LMS was developed jointly by Human Resources, the Privacy Officer, and Contract with implementation of the attached standard protocols on June 25, 2009.

Status: Complete

Complete Date: June 25, 2009

OIG Contact and Staff Acknowledgments

Contact	Jeanne Martin, Associate Director Bedford Office of Healthcare Inspections (603) 222-5872
Contributors	Annette Acosta, MN Alice Morales-Rullan, MSN Katherine Owens, MSN Glen Pickens, BSN Carol Torczon, MSN Jenny Walenta, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare Network Upstate New York (10N2)
Director, Syracuse VA Medical Center (528A7/00)

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: Kirsten E. Gillibrand, Charles E. Schumer
U.S. House of Representatives: Daniel B. Maffei

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