Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00030-160

Combined Assessment Program Review of the Tennessee Valley Healthcare System Nashville, Tennessee

May 5, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
ED	emergency department
EOC	environment of care
facility	Tennessee Valley Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
JC	Joint Commission
MDRO	multidrug-resistant organisms
MEB	Medical Executive Board
MH	mental health
MRSA	Methicillin-resistant *Staphylococcus Aureus*
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PET/CT	positron emission tomography/computed tomography
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, TN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 7, 2011.

Review Results: The review covered seven activities. We made no recommendations in the following activities:

- Coordination of Care
- Medication Management

The facility's reported accomplishment was the development of a tri-fold brochure that identifies the best treatment for elimination of specific infections and the associated cost. The brochure is distributed annually to all medical providers.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Require that fire extinguishers and exits are clear of obstructions. Ensure that portable oxygen tanks are secured and that environmental hazards on the locked mental health units are corrected. Require that annual bloodborne pathogens training and respirator fit testing is completed and documented.

Quality Management: Ensure that the Cardiopulmonary Resuscitation Committee meets monthly, evaluates resuscitation events, analyzes data, and identifies opportunities to improve processes. Require that the Peer Review Committee trends and analyzes peer review results and reports all required elements to the Medical Executive Board quarterly.

Physician Credentialing and Privileging: Ensure that Focused Professional Practice Evaluations are defined, approved, and documented for all physicians who have been newly hired or have added new privileges.

Management of Multidrug-Resistant Organisms: Ensure that employees receive annual education and that the training is consistently documented.

Management of Test Results: Ensure that normal test results are consistently communicated to patients within the specified timeframe.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through March 7, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee,* Report

No. 08-01446-93, March 10, 2009). (See Appendix B for further details.) The facility had a repeat finding in the area of QM.

During this review, we also presented crime awareness briefings for 124 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.

Reported Accomplishment

Antibiogram

The facility's medical media department produced an antibiogram[1] tri-fold brochure for the microbiology department in response to a College of American Pathologists recommendation. The brochure identifies the best treatment for elimination of specific organisms and the associated cost. It also includes current isolation guidelines, discontinuation criteria for isolation, and surveillance screening for MRSA. The brochure is campus specific, and the data comes from the computerized laboratory package that counts the organisms isolated, the antibiotics tested, and the percent susceptible to the antibiotic. The brochure is distributed annually to all medical providers and to other staff as appropriate.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

At the Nashville campus, we inspected the inpatient acute medicine (2N), acute medicine/palliative care (2G), and acute medicine/surgery (3N) units; the locked MH unit (4BN); the gastroenterology, bronchoscopy, and cardiac catheterization laboratories; the surgical intensive care unit; the podiatry and primary care clinics; and the ED. We also

[1] An antibiogram is the result of a laboratory test for the sensitivity of an isolated bacterial strain to different antibiotics. http://www.websters-online-dictionary.org, accessed on March 23, 2011.

inspected the ultrasound, computed tomography, and interventional and general radiology areas.

At the Murfreesboro campus, we inspected the inpatient acute medicine (1A) unit, the locked MH units (7A and 7B), the gastroenterology laboratory, the CLC units (8A, 8B, 9B, East, and West), the medical intensive care unit, primary care clinics (A and C), and the ED. We also inspected PET/CT and general radiology areas.

The facility maintained a generally clean and safe environment. However, we identified the following areas at both campuses that needed improvement.

Fire and Safety. The JC requires that fire extinguishers and exits be clear of obstructions. We found multiple areas where fire extinguishers and exits were blocked by medical equipment, biohazard waste containers, and waiting room furniture.

Environmental Safety. OSHA requires that portable oxygen tanks be secured. We found unsecured portable oxygen tanks in multiple areas.

VHA requires a safe environment for all patients in inpatient MH programs.[2] We found the following environmental hazards on the locked MH units: (a) plastic picture frames in sally ports (secured controlled entryways), (b) a shred box in one sally port, (c) rolling bedside tables in patient rooms, and (d) plastic trash bags on unsecured housekeeping carts.[3]

IC. OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 37 employee training records and found that only five (14 percent) employees had this training documented.

If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 48 employee training records and found that only 31 (65 percent) employees had the required annual fit testing.

[2] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[3] VA National Center for Patient Safety, "Mental Health Environment of Care Checklist," November 1, 2010.

Recommendations

1. We recommended that processes be strengthened to ensure that fire extinguishers and exits are clear of obstructions.

2. We recommended that processes be strengthened to ensure that portable oxygen tanks are secured.

3. We recommended that environmental hazards on the locked MH units be corrected.

4. We recommended that annual bloodborne pathogens training and respirator fit testing be completed and documented.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Resuscitation and Its Outcomes. VHA requires facilities to evaluate resuscitation events and analyze data.[4] Local policy requires that the CPR Committee meet monthly. CPR committee minutes did not reflect discussions related to resuscitation events or data analysis and did not identify opportunities to improve CPR processes. In addition, the committee met only six times between January 2010 and February 2011.

Peer Review. VHA requires that peer review results be trended and analyzed and that the data be reported to the MEB on a quarterly basis.[5] We found that the PRC did not trend and analyze peer review results or adequately report to the MEB. This was a repeat finding from the previous CAP review. During FY 2010, the PRC only reported to the MEB for 3 of the 4 quarters, and the reports did not include all required elements.

[4] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[5] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Recommendations

5. We recommended that the CPR Committee meet monthly, evaluate resuscitation events, analyze data, and identify opportunities to improve CPR processes.

6. We recommended that the PRC trend and analyze peer review results and report all required elements to the MEB quarterly.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

FPPE. VHA requires that a defined and approved FPPE be initiated and documented for all physicians who have been newly hired or have added new privileges.[6] We reviewed the profiles for two newly hired physicians. We found that while FPPEs had been initiated, criteria were not defined or approved. In addition, FPPEs were not documented in MEB minutes.

Recommendation

7. We recommended that FPPEs be defined, approved, and documented for all physicians who have been newly hired or have added new privileges.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

At the Nashville campus, we inspected the acute medicine (2N) and acute medicine/surgery (3N) units. At the Murfreesboro campus, we inspected the CLC East and 9B units. Additionally, we interviewed employees. We did not identify any deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Employee Training. The JC requires that facilities conduct an IC risk assessment to determine the need for staff education on MDRO. The facility's most recent risk assessment stated that staff education was indicated for all

[6] VHA Handbook, 1100.19, *Credentialing and Privileging*, November 14, 2008.

employees during orientation and annually thereafter. We reviewed 37 employee training records to determine whether MDRO education had been provided in accordance with the risk assessment. We found that only five (14 percent) of the records reviewed had documentation of annual MDRO education.

Recommendation

8. We recommended that employees receive annual MDRO education and that the training is consistently documented.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[7]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[8] We reviewed the medical records of 20 outpatients who had normal results and found that only 11 of the 20 records contained documented evidence that the facility had communicated the results to the patients within the specified timeframe.

Recommendation

9. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records and determined that the facility generally met requirements in these areas. We made no recommendations.

[7] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care integrated medical center	
Complexity Level	1A	
VISN	9	
Community Based Outpatient Clinics	Chattanooga, TN Tullahoma, TN McMinnville, TN Cookeville, TN Rockwood, TN Clarksville, TN Ft. Campbell, TN Bowling Green, TN Hopkinsville, TN Dover, TN	
Veteran Population in Catchment Area	302,795	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	255	
• **CLC/Nursing Home Care Unit**	238	
• **Other**	None	
Medical School Affiliation(s)	Vanderbilt University Meharry Medical College	
• **Number of Residents**	695	
	Current FY (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$594	$598
• **Medical Care Expenditures**	$175	$598
Total Medical Care Full-Time Employee Equivalents	3,221	3,224
Workload:		
• **Number of Station Level Unique Patients**	53,579	80,825
• **Inpatient Days of Care:**		
o **Acute Care**	9,523	37,125
o **CLC/Nursing Home Care Unit**	18,412	72,574
Hospital Discharges	2,883	10,472
Total Average Daily Census (including all bed types)	393.9	388.2
Cumulative Occupancy Rate (in percent)	80.5	78.9
Outpatient Visits	151,444	786,459

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure QM experts complete a comprehensive review of the QM Department to redesign the processes used to capture, trend, analyze, document, correct, and follow up required QM activities.	Progress has been made with restructuring of committees, standardization of minutes, standardization of tracking logs, and structuring of agenda (Quality Executive Board grid), which addresses QM items that should be tracked.	N	Y (See pages 4–5)
Emergency/Urgent Care Operations			
2. Ensure all ED registered nurse competency folders are updated and maintained in accordance with local policy.	All ED competency folders are reviewed during the annual performance evaluation period. One hundred percent of the folders are in compliance.	Y	N
Medication Management			
3. Consistently document pain medication effectiveness within the required timeframe.	Pain medication effectiveness documentation is reported to the Bar Code Medication Administration Committee.	Y	N

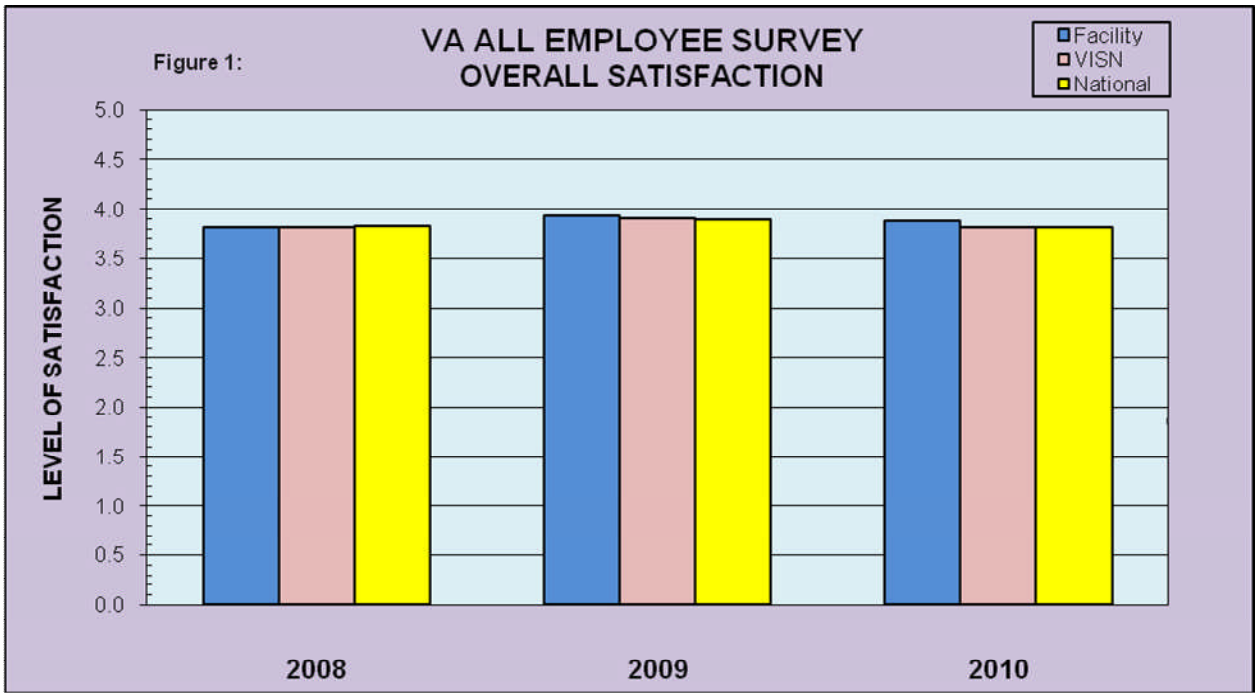
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	58.4	57.8	67.6	60.3	54.4	51.0	49.6	50.7
VISN	62.2	61.2	63.4	62.5	55.5	56.5	54.4	54.7
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	12.61	10.28	15.45	18.28	20.07	15.46
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[10] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 25, 2011

From: Network Director (10N9), VA Mid South Healthcare Network

Subject: **CAP Review of the Tennessee Valley Healthcare System, Nashville, TN**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA CO 10B5 Staff)

1. Thank you for the opportunity to review the draft OIG CAP report for the Tennessee Valley Healthcare System site visit that was conducted the week of March 7, 2011. We concur with the recommendations, and will ensure completion as described in the attached plan by the established target dates.

2. If you have any questions regarding the attached response or action for recommendations please contact Ms. Tammy K. Williams, VISN 9 Continuous Readiness Officer, VISN 9 at 615-695-2143.

(original signed by:)
John Dandridge, Jr.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 21, 2011

From: Director (626/00), Tennessee Valley Healthcare System

Subject: **CAP Review of the Tennessee Valley Healthcare System, Nashville, TN**

To: Director, VA Mid South Healthcare Network (10N9)

1. VA Tennessee Valley Healthcare System appreciates the opportunity to review the OIG report on the CAP Review of the Tennessee Valley Healthcare System, Nashville, TN.

2. Please find attached our response to each recommendation provided in the report.

3. If you have any questions regarding the response to the recommendations in the report or if there is any additional information required, you may contact Mr. Paul Crews, Chief, Quality Management Services at 615-873-7080.

(original signed by:)
Juan A. Morales, RN, MSN

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 processes be strengthened to ensure that fire extinguishers and exits are clear of obstructions.

Concur

Action Completed: March 10, 2011

1. Obstructions were removed that prevented access to fire safety equipment and exits.
2. TVHCS staff were re-educated on the requirement not to obstruct fire safety equipment and exits.
3. Weekly Environmental rounds will monitor for continued compliance.
4. The Environment of Care Committee will review significant outstanding issues quarterly or sooner as appropriate.

Recommendation 2. We recommended that processes be strengthened to ensure that portable oxygen tanks are secured.

Concur

Action Completed: March 10, 2011

1. All portable oxygen tanks were secured.
2. TVHCS staff were re-educated on the requirement and proper procedure for securing portable oxygen tanks.
3. Weekly environmental rounds will monitor for continued compliance.
4. The Environment of Care Committee will review significant outstanding issues quarterly or sooner as appropriate.

Recommendation 3. We recommended that environmental hazards on the locked MH units be corrected.

Concur

Action Completed: April 8, 2011

1. Environmental hazards were removed at the time of inspection.
2. Shred Ahead box relocated.
3. Weekly environmental rounds will monitor for continued compliance.

4. The Environment of Care Committee will review significant outstanding issues quarterly or sooner as appropriate.

Recommendation 4. We recommended that annual bloodborne pathogens training and respirator fit testing be completed and documented.

Concur

Target date for completion: September 30, 2011

1. Executive leadership will re-emphasize compliance with annual requirements for blood borne pathogens training and respirator fit testing to all Service Chiefs.
2. Compliance with training requirements will be included in the employee annual performance review.
3. Compliance with annual infection control training will be reported quarterly to the Infection Control Committee.
4. Process for identification of employees requiring fit testing is under revision. New process will involve identification of anyone who has a job related function within airborne isolation areas. All staff will be medically evaluated for fit testing prior to initial performance of their functions.
5. Vanderbilt University Medical Center fit testing will be accepted, when appropriately documented, for those employees who work in both hospitals.
6. Additional approved respirator styles will be offered to Vanderbilt employees tested using another mask.
7. A schedule for fit testing will be posted in employee areas.

Recommendation 5. We recommended that the CPR Committee meet monthly, evaluate resuscitation events, analyze data, and identify opportunities to improve CPR processes.

Concur

Target date for completion: September 30, 2011

1. The CPR Committee will meet monthly.
2. The data collection form for resuscitative events has been revised and utilizes information from the American Heart Association.
3. Performance goals have been developed to assist in developing performance improvement plans.
4. Clinical Nurse Leaders and Nurse Managers will review code sheets prior to submission to Quality Management Service and Critical Care Educator.
5. Critical Care Educator will trend and analyze data for reporting to the CPR Committee monthly.
6. Quality Management Specialist is assigned to the CPR Committee for assistance with data gathering, trending and analysis.
7. Joint Commission Consultant is scheduled to provide a presentation on effective documentation and data gathering, trending and analysis on April 27, 2011.

Recommendation 6. We recommended that the PRC trend and analyze peer review results and report all required elements to the MEB quarterly.

Concur

Action Completed: April 19, 2011

1. A report has been generated for FY10 with multiple graphs trending the initial levels of Peer Review, final levels of Peer Review, all changes made by the Peer Review Committee and the numbers of Peer Reviews that the Committee did not change for these four quarters.
2. This information was presented at the April MEB meeting.
3. This report will be placed on the agenda quarterly and included in the MEB minutes.

Recommendation 7. We recommended that FPPEs be defined, approved, and documented for all physicians who have been newly hired or have added new privileges.

Concur

Action Completed: March 14, 2011

As of March 14, 2011, the minutes of the PSB/MEB will include documentation of initial FPPE as follows:

- The FPPE will be completed once the provider officially comes on board. The evaluation will include a review of 10 charts per month for a period of 3 months (depending on the requirement for those particular privileges).
- The final report will be forwarded to the medical Staff Office for presentation to the Professional Standards Board/Medical Executive Board (PSB/MEB).
- The minutes of the PSB/MEB will be reviewed and approved by the Director and this will serve as initial notification.
- The completion of the FPPE will be expanded in the PSB/MEB minutes to include the results.
- The Medical Staff Office will monitor compliance.

Recommendation 8. We recommended that employees receive annual MDRO education and that the training is consistently documented.

Concur

Target date for completion: September 30, 2011

1. Executive leadership will re-emphasize compliance with annual requirements for annual infection control training to all Service Chiefs.
2. Compliance with training requirements will be included in the employee annual performance review.

3. Compliance with annual infection control training will be reported quarterly to the Infection Control Committee.

Recommendation 9. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: May 1, 2011

1. The Chief of Staff office has sent a notice to all Clinical Service Chiefs directing them to communicate with their providers at the next staff meeting regarding the importance of communicating test results, including normal values, to their patients.
2. Information disseminated no later than April 22, 2011.
3. The Chief of Staff office will provide follow up to ensure all Service Chiefs have communicated with their providers.
4. Compliance will be monitored through record reviews for communication of normal lab values within 14 days.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Contributors	Tishanna McCutchen, NP, Team Leader Nancy Albaladejo, RN Karen Sutton, BS Toni Woodard Susan Zarter, RN Brian Celatka, Special Agent, Office of Investigations Richard Ellison, Special Agent, Office of Investigations

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