Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00843-169

Community Based Outpatient Clinic Reviews Georgetown, DE and Ventnor, NJ Guayama and Ponce, PR Goshen, IN Belton and Nevada, MO Capitola and French Camp (Stockton), CA

May 17, 2011

Washington, DC 20420

Why We Did This Review

The VA Office of Inspector General (OIG) is undertaking a systematic review of the Veterans Health Administration's (VHA's) community-based outpatient clinics (CBOCs) to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in a more equitable and cost-effective manner. As a result, VHA expanded the Ambulatory and Primary Care Services to include CBOCs located throughout the United States. CBOCs were established to provide more convenient access to care for currently enrolled users and to improve access opportunities within existing resources for eligible veterans not currently served.

Veterans are required to receive one standard of care at all VHA health care facilities. Care at CBOCs needs to be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

Glossary

A1c	glycated hemoglobin
AED	automated external defibrillator
BLS	Basic Life Support
CDC	Center for Disease Control and Prevention
C&P	credentialing and privileging
CBOC	community based outpatient clinic
COTR	Contracting Officer's Technical Representative
DM	Diabetes Mellitus
EKG	electrocardiogram
EOC	environment of care
ECMS	Executive Committee of the Medical Staff
FY	fiscal year
FTE	full-time employee equivalents
HCS	Health Care System
HIPAA	Health Insurance Portability and Accountability Act
IC	infection control
IT	Information Technology
JC	Joint Commission
LCSW	Licensed Clinical Social Worker
LIP	Licensed Independent Practitioner
LPN	Licensed Practical Nurse
MH	mental health
MST	military sexual trauma
NP	nurse practitioner
OSHA	Occupational Safety and Health Administration
OI&T	Office of Information and Technology
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PII	personally identifiable information
PTSD	Post-Traumatic Stress Disorder
PCMM	Primary Care Management Model
PCP	primary care provider
PSB	Professional Standards Board
Qtr	quarter

RN	registered nurse
SSN	social security number
SOP	standard operating procedure
VANIHCS	VA Northern Indiana Health Care System
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Purpose: We conducted the review of nine CBOCs during the week of February 7, 2011. CBOCs were reviewed in VISN 4 at Georgetown, DE and Ventnor, NJ; in VISN 8 at Guayama and Ponce, PR; in VISN 11 at Goshen, IN; in VISN 15 at Belton and Nevada, MO; and, in VISN 21 at Capitola and French Camp (Stockton), CA. The parent facilities of these CBOCs are Wilmington VAMC, VA Caribbean HCS, VA Northern Indiana HCS, Kansas City VAMC, and VA Palo Alto HCS, respectively. The purpose was to evaluate selected activities, assessing whether the CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

Recommendations: The VISN and Facility Directors, in conjunction with the respective CBOC manager, should take appropriate actions to:

Wilmington VAMC

- Require that the PSB grant privileges appropriate for the services provided at the Georgetown and Ventnor CBOCs.
- Improve processes to communicate normal test results to patients and monitor compliance at the Georgetown CBOC.

VA Caribbean HCS

- Ensure that providers use the template required by local policy to document communication of critical laboratory results at the Guayama and Ponce CBOCs.
- Require that normal test results be communicated to patients within the specified timeframe at the Guayama CBOC.
- Define in the local policy how medical emergencies, including the use of equipment and medications, are to be managed at the Ponce CBOC, and educate staff accordingly.

VA Northern Indiana HCS

- Require that employees receive BLS training within the timeframe specified in facility policy at the Goshen CBOC.
- Require that auditory privacy be maintained during the check-in process at the Goshen CBOC.
- Require that the COTR develop a process to validate the prorated capitated rate calculation submitted by the contractor on the monthly invoice.
- Require that the VANIHCS Director determine the total amount of overpayments to the contractor during the contract period as a result of ineligible enrollees and, with the assistance of the Regional Counsel, assess the collectability of the overpayment.

- Require that the VANIHCS Director comply with the contract terms that specify VA maintain the authority to end enrollment of patients.

Kansas City VAMC

- Require that the service chief complete the OPPE assessments, according to facility policy, for providers at both the Belton and Nevada CBOCs.
- Ensure the PSB submit appointment recommendations to ECMS.
- Include in the ECMS meeting minutes the documents reviewed and the rationale for the recommendation decision.
- Require that normal test results be consistently communicated to patients within the specified timeframe at the Belton CBOC.
- Collect, analyze, and report hand hygiene data at the Belton and Nevada CBOCs.
- Require the Chief of OI&T evaluate identified IT security vulnerabilities and implement appropriate IT security measures at the Belton and Nevada CBOCs.
- Complete annual safety and fire inspections at the Nevada CBOC.
- Improve access for disabled veterans at the Belton CBOC.
- Require that exit routes remain free and unobstructed at the Belton CBOC.
- Require that all PII be secured and protected at the Belton CBOC.
- Complete AED preventive maintenance every 6 months as required by facility policy at the Belton and Nevada CBOCs.

VA Palo Alto HCS

- Require ordering providers to document patient notification and treatment actions in response to critical test results at the Capitola CBOC.
- Ensure clinicians communicate normal test results to patients within the specified timeframe at the Stockton CBOC.
- Consistently collect, measure, and analyze hand hygiene data at the Capitola CBOC.

Comments

The VISN and facility Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes A–J, pages 30–49 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by Patricia Christ,
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Part I. Objectives and Scope

Objectives. The purposes of this review are to:

- Determine whether CBOC performance measure scores are comparable to the parent VAMC or HCS outpatient clinics.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[1]
- Determine whether appropriate notification and follow-up action are documented in the medical record when critical laboratory test results are generated.
- Determine the extent patients are notified of normal laboratory test results.
- Determine whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1[2] in the areas of environmental safety and emergency planning.
- Determine whether the CBOC primary care and mental health contracts were administered in accordance with contract terms and conditions.
- Determine whether primary care active panel management and reporting are in compliance with VHA Handbook 1101.02.[3]

Scope. The topics discussed in this report include:

- Quality of Care Measures
- C&P
- Management of Laboratory Results
- EOC and Emergency Management
- CBOC Contracts

We formulated a list of CBOC characteristics and developed an online survey for data collection. The surveys were completed by the respective CBOC managers. The characteristics included identifiers and descriptive information for CBOC evaluation.

We reviewed CBOC policies, performance documents, provider C&P files, and nurses' personnel records. For each CBOC, we evaluated the quality of care measures by reviewing 50 randomly selected patients with a diagnosis of DM and 30 female patients between the ages of 52 and 69 years of age who had mammograms, unless fewer

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
[3] VHA Handbook 1101.02, *Primary Care Management Module (PCMM),* April 21, 2009.

patients were available. We reviewed the medical records of these selected patients to determine compliance with VHA performance measures.

We also reviewed medical records for 10 patients who had critical laboratory results and 10 patients with normal laboratory results or fewer if 10 were not available. We used the term *critical value or result* as defined in VHA Directive 2009-019.[4] A critical test result is defined as those values or interpretations that, if left untreated, could be life threatening or place the patient at serious risk. All emergent test results and some abnormal test results constitute critical values or results. Although not defined in the directive, we used the term *normal results* to describe test or procedure results that are neither emergent nor abnormal, or results that are within or marginally outside the expected or therapeutic range.

We conducted EOC inspections to determine the CBOCs' cleanliness and condition of the patient care areas, condition of equipment, adherence to clinical standards for IC and patient safety, and compliance with patient data security requirements. We evaluated whether the CBOCs had a local policy/guideline defining how health emergencies, including MH emergencies, are handled.

We evaluated whether the Goshen CBOC contract provided guidelines that the contractor needed to follow in order to address quality of care issues. We also verified that the number of enrollees or visits reported was supported by collaborating documentation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Part II. Results and Recommendations

A. VISN 4, Wilmington VAMC – Georgetown and Ventnor

CBOC Characteristics

Table 1 shows the characteristics of the Georgetown and Ventnor CBOCs.

CBOC Characteristics	Georgetown	Ventnor
Type of CBOC	VA Staffed	VA Staffed
Number of Uniques, FY 2010	2,473	2,122
Number of Visits, FY 2010	9,570	6,720
CBOC Size[5]	Mid-Size	Mid-Size
Locality	Rural	Urban
FTE Provider(s)	2.0	1.8
Type Providers Assigned	PCP NP Psychiatrist Psychologist LCSW	PCP NP Psychiatrist LCSW
Ancillary Staff Assigned	RN Social Worker	RN LPN Social Worker
Type of MH Providers	Psychologist LCSW PCP	Psychiatrist LCSW PCP
Provides MH Services	Yes	Yes
• **Evening Hours**	No	No
• **Weekends**	No	No
• **Plan for Emergencies Outside of Business Hours**	No	No
• **Provided Onsite**	Substance Use Disorder PTSD MST Homelessness Psychosocial Rehab	Substance Use Disorder PTSD Homelessness Psychosocial Rehab
• **Referrals**	Another VA facility Non-VA fee-basis or contract	Another VA facility Non-VA fee-basis or contract
• **Tele-Mental Health Services**	Yes (Medication management, individual therapy)	No
Specialty Care Services Onsite	Yes	Yes
• **Provided Onsite**	Podiatry Women's Health	Podiatry Women's Health
• **Referrals**	Another VA facility	Another VA facility
Ancillary Services Provided Onsite	Laboratory EKG	Laboratory EKG
Miles to Parent Facility	84.6	88.5

Table 1. CBOC Characteristics

[5] Based on the number of unique patients seen as defined by the VHA Handbook 1160.01.

Quality of Care Measures[6]

DM

Diabetes is the leading cause of new cases of blindness among adults age 20−74, and diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50−60 percent. Table 2 displays the parent facility and the Georgetown and Ventnor CBOCs' compliance in screening for retinopathy.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM – Retinal Eye Exam	70%	460 Wilmington VAMC	51	59	**91**
		460GA Georgetown CBOC	39	49	**80**
		460HE Ventnor CBOC	46	49	**94**

Table 2. Retinal Exam, FY 2010

A1c is a blood test that measures average blood glucose (sugar) levels. Research studies in the United States and abroad have found that improved glycemic control benefits people with either type I or type II diabetes. In general, for every 1 percent reduction in A1c, the relative risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent. The American Diabetes Association recommends an A1c of less than 7 percent. Patients with poorly controlled diabetes (A1c greater than 9 percent) are at higher risk of developing diabetic complications. Measuring A1c assesses the effectiveness of therapy. For this indicator, low scores indicate better compliance. Table 3 displays the scores of the parent facility and the Georgetown and Ventnor CBOCs.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM –A1c > 9 or not done in past year	21%	460 Wilmington VAMC	11	59	**19**
		460GA Georgetown CBOC	12	49	**24**
		460HE Ventnor CBOC	6	49	**12**

Table 3. A1c Testing, FY 2010

At the Georgetown CBOC, managers will conduct monthly reviews of patients diagnosed with DM who have A1c levels greater than 9.

[6] Parent facility scores were obtained from http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Providers will be notified and prompted to request a consult with the Diabetes Educator/NP who will provide education, treatment, and management for the patients. Additionally, the Diabetes Educator will provide education to the clinical staff.

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year.[7] It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women 40 and older. Comparisons of the Georgetown and Ventnor CBOCs to the parent facility's breast cancer screening are listed in Table 4.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
Mammography, 50-69 years old	77%	460 Wilmington VAMC	21	26	**86**
		460GA Georgetown CBOC	20	24	**83**
		460HE Ventnor CBOC	6	9	**67**

Table 4. Women's Health, FY 2010

To improve breast cancer screening at the Ventnor CBOC, clinical managers will query the mammography screening clinical reminder data monthly to ensure providers addressed the performance measure. Trends will be identified and reviewed with the respective provider. Further, the Women's Health NP and the clinical manager will collect data on mammogram orders, patient notifications, and the entry of outside mammogram results into patients' electronic records for tracking and reporting.

C&P

We reviewed the C&P files of four providers and the personnel folders of three nurses at the Georgetown CBOC and five providers and three nurses at the Ventnor CBOC. All providers possessed a full, active, current, and unrestricted license, and privileges were appropriate for services rendered. All nurses' license and education requirements were verified and documented. Service-specific criteria for OPPE had been developed and approved, and we found sufficient performance data to meet current requirements. OPPE included minimum competency criteria for privileges. However, we found the following area that required improvement:

[7] American Cancer Society, Cancer Facts & Figures 2009.

Privileges

We found that the PSB granted clinical privileges for procedures that were not performed at either CBOC. Two providers (one at the Georgetown CBOC and one at the Ventnor CBOC) were granted privileges for specific procedures such as thoracentesis,[8] cardioversion,[9] and intubation of the trachea during emergencies. VA Handbook 1100.19 requires that facility managers grant clinical privileges that are facility, setting, and provider specific.

Recommendation 1. We recommended that the PSB grant privileges appropriate for the services provided at the Georgetown and Ventnor CBOCs.

Management of Laboratory Results

VHA Directive 2009-019 requires critical test results to be communicated to the ordering provider or surrogate provider within a timeframe that allows for prompt attention and appropriate clinical action to be taken. VHA also requires that the ordering provider communicate test results to patients so that they may participate in health care decisions. Each parent facility is required to develop a written policy for communicating test results to providers and documenting communications in the medical record, to include a system for surrogate providers to receive results when the ordering provider is not available. In addition, ordering providers are required to communicate outpatient test results (those not requiring immediate attention) to patients no later than 14 calendar days from the date on which the results are available to the ordering provider.

We reviewed the parent facility's policies and procedures and the medical records of patients who had tests resulting in critical values and normal values. We found the following, with one process that needed improvement.

Critical Laboratory Results

We found that the Georgetown and the Ventnor CBOCs had effective processes in place to communicate critical laboratory test results to ordering providers and patients. We reviewed the medical records of 20 patients (10 at the Georgetown CBOC and 10 at the Ventnor CBOC) who had critical laboratory results and found that 19 (95 percent) records contained documented evidence of patient notifications and follow-up actions.

Normal Laboratory Results

We reviewed 10 medical records at the Ventnor CBOC and found effective processes in place to communicate normal test results. However, we found that the Georgetown

[8] Thoracentesis is an invasive procedure to remove fluid or air from the pleural space (body cavity that surrounds the lungs) for diagnostic or therapeutic purposes.
[9] Cardioversion is a procedure that delivers an electrical shock to the heart to convert an abnormal heart rhythm back to a normal rhythm.

CBOC required improvement in communicating normal laboratory test results to patients. We reviewed the medical records of 10 patients and determined that 4 (40 percent) indicated that staff communicated normal results to patients within 14 calendar days from the date the results were available to the ordering provider.

Recommendation 2. We recommended that facility managers improve processes to communicate normal test results to patients and monitor compliance at the Georgetown CBOC.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs met most standards, and the environments were generally clean and safe. We found that the IC program monitored data and appropriately reported that data to relevant committees.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies, including MH, are handled. Both CBOCs had policies that outlined management of medical and MH emergencies, and staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

B. VISN 8, VA Caribbean HCS – Guayama and Ponce

CBOC Characteristics

Table 5 shows the characteristics of the Guayama and Ponce CBOCs.

CBOC Characteristics	Guayama	Ponce
Type of CBOC	VA Staffed	VA Staffed
Number of Uniques, FY 2010	1,533	11,500
Number of Visits, FY 2010	9,114	120,913
CBOC Size	Mid-Size	Very Large
Locality	Urban	Urban
FTE Provider(s)	1.70	11.47
• **Type Providers Assigned**	Family Medicine Physician Internal Medicine Physician Psychiatrist LCSW	Family Medicine Physician Internal Medicine Physician Psychiatrist Psychologist LCSW
• **Ancillary Staff Assigned**	RN LPN Pharmacist Social Worker	RN LPN Pharmacist Social Worker Technician/Technologists Health/Medical Technologist Dietician
Type of MH Providers	Psychologist Psychiatrist LCSW	Psychologist Psychiatrist LCSW Addiction Counselors
Provides MH Services	Yes	Yes
• **Evening Hours**	No	No
• **Weekends**	No	No
• **Plan for Emergencies Outside of Business Hours**	No	Yes
• **Provided Onsite**	Substance Use Disorder PTSD	Substance Use Disorder PTSD
• **Referrals**	Another VA facility Non-VA fee-basis or contract	Another VA facility Non-VA fee-basis or contract
• **Tele-Mental Health Services**	No	No
Specialty Care Services Onsite	Yes	Yes
• **Services Provided Onsite**	Women's Health	Cardiology Optometry Podiatry Urology Women's Health
• **Procedures Provided Onsite**	No	Endoscopy Cystoscopy Ambulatory Surgery
• **Referrals**	Another VA facility Non-VA fee-basis or contract	Another VA facility Non-VA fee-basis or contract

CBOC Characteristics (cont'd)	Guayama	Ponce
Ancillary Services Provided Onsite	Laboratory EKG	Laboratory Pharmacy Physical Medicine Radiology EKG
Miles to Parent Facility	50	70

Table 5. CBOC Characteristics

Quality of Care Measures

DM

Diabetes is the leading cause of new cases of blindness among adults age 20−74, and diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50−60 percent. Table 6 displays the parent facility and the Guayama and Ponce CBOCs' compliance in screening for retinopathy.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM – Retinal Eye Exam	70%	672 VA Caribbean HCS	45	47	**96**
		672GE Guayama CBOC	48	48	**100**
		672BO Ponce CBOC	48	50	**96**

Table 6. Retinal Exam, FY 2010

A1c is a blood test that measures average blood glucose (sugar) levels. Research studies in the United States and abroad have found that improved glycemic control benefits people with either type I or type II diabetes. In general, for every 1 percent reduction in A1c, the relative risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent. The American Diabetes Association recommends an A1c of less than 7 percent. Patients with poorly controlled diabetes (A1c greater than 9 percent) are at higher risk of developing diabetic complications. Measuring A1c assesses the effectiveness of therapy. For this indicator, low scores indicate better compliance. Table 7 displays the scores of the parent facility and the Guayama and Ponce CBOCs.

Measure	*Meets Target*	*Facility*	*Qtr3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM –A1c > 9 or not done in past year	21%	672 VA Caribbean HCS	7	47	**9**
		672GE Guayama CBOC	6	48	**13**
		672BO Ponce CBOC	6	50	**12**

Table 7. A1c Testing, FY 2010

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women 40 and older. Comparisons of the Guayama and Ponce CBOCs' to the parent facility's breast cancer screening are listed in Table 8.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
Mammography, 50-69 years old	77%	672 VA Caribbean HCS	25	31	**78**
		672GE Guayama CBOC	10	10	**100**
		672BO Ponce CBOC	27	30	**90**

Table 8. Women's Health, FY 2010

C&P

We reviewed the C&P files of three providers and the personnel folders of three nurses at the Guayama CBOC and five providers and four nurses at the Ponce CBOC. All providers possessed a full, active, current, and unrestricted license; and privileges were appropriate for services rendered. All nurses' license and education requirements were verified and documented. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. OPPE included minimum competency criteria for privileges.

Management of Laboratory Results

VHA Directive 2009-019 requires critical test results to be communicated to the ordering provider or surrogate provider within a timeframe that allows for prompt attention and appropriate clinical action to be taken. VHA also requires that the ordering provider communicate test results to patients so that they may participate in health care decisions. Each parent facility is required to develop a written policy for communicating test results to providers and documenting communications in the medical record, to include a system for surrogate providers to receive results when the ordering provider is not available. In addition, ordering providers are required to communicate outpatient test results (those not requiring immediate attention) to patients no later than 14 calendar days from the date on which the results are available to the ordering provider.

We reviewed the parent facility's policies and procedures and the medical records of patients who had tests resulting in critical values and normal values. We identified the following areas that needed improvement.

Critical Laboratory Results

We found that the Guayama and Ponce CBOCs generally had processes in place to communicate critical laboratory test results to providers and patients. We reviewed the medical records of 20 patients (10 at the Guayama CBOC and 10 at the Ponce CBOC) who had critical laboratory results and found that 19 (95 percent) records contained evidence of provider and patient notification and follow-up actions. However, local policy required that providers use a specific template to document communication of critical laboratory results, and we found that the template was used in 6 of the 20 (30 percent) medical records.

Recommendation 3. We recommended that providers use the template required by local policy to document communication of critical laboratory results at the Guayama and Ponce CBOCs.

Normal Laboratory Results

We found that the Guayama CBOC did not have effective processes to communicate normal laboratory test results to patients. We reviewed the medical records of 20 patients (10 at the Guayama CBOC and 10 at the Ponce CBOC) and determined the Ponce CBOC communicated with 9 patients (90 percent) within the required timeframe. However, the Guayama CBOC had communicated normal test results to 4 patients (40 percent) within 14 calendar days from the date the results were available to the ordering provider.

Recommendation 4. We recommended that normal test results be communicated to patients within the specified timeframe at the Guayama CBOC.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs met most standards, and the environments were generally clean and safe. We found that the IC program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards.

Emergency Management

Both CBOCS had local policies defining how medical and MH emergencies are handled. However, Ponce CBOC staff could not readily describe what measures should be taken in a medical emergency. The Ponce CBOC local policy did not clearly define when or what emergency measures should be instituted. The local policy did not define when staff would use advanced life-saving measures, including emergency medications and airway stabilization equipments, versus using basic life-saving measures while activating the local emergency response system (911).

Recommendation 5. We recommended that the local policy define how medical emergencies, including the use of equipment and medications, are to be managed at the Ponce CBOC, and educate staff accordingly.

C. VISN 11, VA Northern Indiana HCS – Goshen

CBOC Characteristics

Table 9 shows the characteristics of the Goshen CBOC.

CBOC Characteristics	Goshen
Type of CBOC	Contract
Number of Uniques, FY 2010	3,233
Number of Visits, FY 2010	9,005
CBOC Size	Mid-Size
Locality	Urban
FTE Provider(s)	3.75
Type Providers Assigned	PCP NP Psychiatrist Psychologist LCSW
Ancillary Staff Assigned	RN LPN Technician Health Technologist
Type of MH Providers	Psychologist Psychiatrist LCSW
Provides MH Services	Yes
• **Evening Hours**	Yes
• **Weekends**	No
• **Plan for Emergencies Outside of Business Hours**	No
• **Provided Onsite**	PTSD
• **Referrals**	Another VA facility
• **Tele-Mental Health Services**	Yes (medication management)
Specialty Care Services Onsite	No
• **Referrals**	Another VA facility Non-VA fee-basis or contract
Ancillary Services Provided Onsite	Laboratory Physical Medicine Radiology EKG
Miles to Parent Facility	55

Table 9. CBOC Characteristics

Quality of Care Measures

DM

Diabetes is the leading cause of new cases of blindness among adults age 20−74 and diabetic retinopathy causes 12,000–24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50−60 percent. Table 10 displays the parent facility's and the Goshen CBOC's compliance in screening for retinopathy.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM – Retinal Eye Exam	70%	610 VANIHCS	71	72	**99**
		610GC Goshen CBOC	45	49	**92**

Table 10. Retinal Exam, FY 2010

A1c is a blood test that measures average blood glucose (sugar) levels. Research studies in the United States and abroad have found that improved glycemic control benefits people with either type I or type II diabetes. In general, for every 1 percent reduction in A1c, the relative risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent. The American Diabetes Association recommends an A1c of less than 7 percent. Patients with poorly controlled diabetes (A1c greater than 9 percent) are at higher risk of developing diabetic complications. Measuring A1c assesses the effectiveness of therapy. For this indicator, low scores indicate better compliance. Table 11 displays the scores of the parent facility and the Goshen CBOC.

Measure	*Meets Target*	*Facility*	*Qtr3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM –A1c > 9 or not done in past year	19%	610 VANIHCS	13	72	**18**
		610GC Goshen CBOC	7	49	**14**

Table 11. A1c Testing, FY 2010

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year. It is most common in women age 50 and older. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women age 40 and older. Table 12 displays the comparison of the Goshen CBOC to the parent facility's breast cancer screening.

Measure	Meets Target	Facility	Qtr 3 Numerator	Qtr 3 Denominator	Qtr 3 (%)
Mammography, 50-69 years old	77%	610 VANIHCS	16	19	**85**
		610GC Goshen CBOC	24	26	**92**

Table 12. Women's Health, FY 2010

C&P

We reviewed the C&P files of five providers and the personnel folders of four nurses at the Goshen CBOC. All providers possessed a full, active, current, and unrestricted license. All nurses' license and education requirements were verified and documented. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. However, we found the following area that needed improvement.

BLS

According to facility policy, all new hires are required to complete BLS training within 30 days of employment. However, a LIP was hired in September 2010 and did not receive the BLS training until January 2011. The absence of BLS training may lead to an undesirable clinical outcome in the event of an emergency.

Setting-Specific Clinical Privileges

The PSB granted clinical privileges to one provider for a procedure that was not performed at the CBOC. The provider was granted privileges for minor suturing. According to VHA Handbook 1100.19, providers may only be granted privileges that are actually performed at the VA-specific facility. The facility had discovered this issue prior to our arrival and planned to address it at the next PSB committee meeting; therefore, we made no recommendations.

Recommendation 6. We recommended that employees receive BLS training within the timeframe specified in facility policy at the Goshen CBOC.

Management of Laboratory Results

VHA Directive 2009-019 requires critical test results to be communicated to the ordering provider or surrogate provider within a timeframe that allows for prompt attention and appropriate clinical action to be taken. VHA also requires that the ordering provider communicate test results to patients so that they may participate in health care decisions. Each parent facility is required to develop a written policy for communicating test results to providers and documenting communications in the medical record, to include a system for surrogate providers to receive results when the ordering provider is not available. In addition, ordering providers are required to communicate outpatient test results (those not requiring immediate attention) to

patients no later than 14 calendar days from the date of which the results are available to the ordering provider.

We reviewed the parent facility's policies and procedures and the medical records of patients who had tests that resulted in critical values and normal values. We determined that the facility had developed a written policy and had implemented an effective reporting process for test results.

Critical Laboratory Results

We found that the Goshen CBOC had effective processes in place to communicate critical laboratory test results to ordering providers and patients. We reviewed the medical records of 10 patients who had critical laboratory results and found that all records contained documented evidence of patient notification and follow-up actions.

Normal Laboratory Results

We found that the Goshen CBOC had effective processes in place to communicate normal laboratory test results to patients. We reviewed the medical records of 10 patients and determined that the CBOC had communicated normal results to all patients within 14 calendar days from the date the results were available to the ordering provider.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. The CBOC met most standards, and the environment was generally clean and safe. We found that the IC program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. However, we identified the following area that needed improvement.

Auditory Privacy

The auditory privacy was inadequate for patients during the check-in process. VHA policy requires auditory privacy when staff discuss sensitive patient issues.[10] Patients communicate with staff through a sliding glass window located in the waiting area. Patients are asked to provide, at minimum, their name and reason for visit. During our site visit, we observed incoming patients standing inside the designated zone of privacy. The staff did not instruct incoming patients to stand behind the posted sign, which designated the zone of privacy.

[10] VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006.

Recommendation 7. We recommended that the staff ensure that the auditory privacy zone is maintained during the check-in process at the Goshen CBOC.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies, including MH, are handled. Both CBOCs had policies that outlined management of medical and MH emergencies, and staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

CBOC Contract

Goshen CBOC

The contract for the Goshen CBOC is administered through the VANIHCS for primary medical care for all eligible Veterans in VISN 11. Contracted services with Ambulatory Care Solutions, LLC began on July 1, 2008, with a base year ending September 30, 2009, and 4 option years extending the contract through September 30, 2013. There were 2.6 FTE PCPs composed of one physician and two mid-level practitioners. The contractor was compensated at a monthly capitated rate per enrollee. The CBOC had 3,233 unique primary medical care enrollees with 9,005 visits as reported on the FY 2010 CBOC Characteristics (see Table 9).

MH services are provided onsite by VA staff. The contractor provides the office space to accommodate the services. During Qtr 3, FY 2010, there were 2,179 MH encounters at the CBOC.

We reviewed the contract to determine the contract type, the services provided, the invoices submitted, and supporting information. We also performed inquiries of key VANIHCS and contractor personnel. Our review focused on documents and records for Qtr 3, FY 2010. We reviewed the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. We reviewed paid capitation rates for compliance with the contract; form and substance of the contract invoices for ease of data analysis by the COTR; and duplicate, missing, or incomplete SSNs on the invoices.

The VHA PCMM Coordinator is responsible for maintaining currency of information in the PCMM database. VANIHCS has approximately 38,000 active patients with approximately 3,000 active patients assigned to the Goshen CBOC. We reviewed PCMM data reported by VSSC and the VANIHCS for compliance with VHA policies. We made inquiries about the number of patients who were unassigned, assigned to more than one PCP, or potentially deceased.

We noted the following:

1. Analytical tests performed on the list of enrollees for the months of April, May, and June 2010 identified approximately $12,500 in overpayments. These

overpayments were made because the VA did not track eligible enrollees based on an annual qualifying visit as required by the contract.

2. The COTR relied on data provided by contractor and did not have an independent process to validate the prorated capitated rate calculation for disenrolled and unbillable enrollees. The contract required a prorated portion of the capitated rate during the month a patient was disenrolled or became ineligible to be billed if service was not provided during that month. The VA did not validate this calculation on the contractor's invoice.

3. VANIHCS allowed the contractor to terminate patient enrollment at the CBOC. This is a conflict of interest and not allowed by the contract, which states the VA has "sole authority to enroll and end enrollment of patients in this CBOC."

More recently, VANIHCS implemented a new invoice validation process. We commend VANIHCS for this process improvement, which was initiated in October 2010. This new process allowed the facility to accurately identify eligible enrollees and ineligible enrollees who have not had a qualifying visit within the prior 12 months and resulted in a more accurate number of billable enrollees.

Recommendation 8. We recommended that the COTR develop a process to validate the prorated capitated rate calculation submitted by the contractor on the monthly invoice.

Recommendation 9. We recommended that the VANIHCS Director determine the total amount of overpayments to the contractor during the contract period as a result of ineligible enrollees and, with the assistance of the Regional Counsel, assess the collectability of the overpayment.

Recommendation 10. We recommended that the VANIHCS Director comply with the contract terms, specifically that the VA maintain the authority to end enrollment of patients.

D. VISN 15, Kansas City VAMC – Belton and Nevada

CBOC Characteristics

Table 13 shows the characteristics of the Belton and Nevada CBOCs.

CBOC Characteristics	Belton	Nevada
Type of CBOC	VA Staffed	VA Staffed
Number of Uniques, FY 2010	1,772	1,942
Number of Visits, FY 2010	4,558	6,424
CBOC Size	Mid-Size	Mid-Size
Locality	Urban	Rural
FTE Provider(s)	1.98	2.0
Type Providers Assigned	PCP	PCP NP LCSW
Ancillary Staff Assigned	RN LPN Medical Technician	RN LPN Medical Technician
Type of MH Providers	N/A	LCSW
Provides MH Services	No	Yes
• **Evening Hours**	N/A	No
• **Weekends**	N/A	No
• **Plan for Emergencies Outside of Business Hours**	No	No
• **Provided Onsite**	N/A	General MH
• **Referrals**	Another VA facility	Another VA facility
• **Tele-Mental Health Services**	No	Yes (group therapy)
Specialty Care Services Onsite	No	No
• **Referrals**	Another VA facility	Another VA facility Non-VA fee-basis or contract
Ancillary Services Provided Onsite	Laboratory EKG	Laboratory EKG
Miles to Parent Facility	20.75	95

Table 13. CBOC Characteristics

Quality of Care Measures

DM

Diabetes is the leading cause of new cases of blindness among adults age 20−74, and diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50−60 percent. Table 14 displays the parent facility and the Belton and Nevada CBOCs' compliance in screening for retinopathy.

Measure	Meets Target	Facility	Qtr 3 Numerator	Qtr 3 Denominator	Qtr 3 (%)
DM – Retinal Eye Exam	70%	589 Kansas City VAMC	54	62	**86**
		589GB Belton CBOC	35	45	**78**
		589GD Nevada CBOC	34	42	**81**

Table 14. Retinal Exam, FY 2010

A1c is a blood test that measures average blood glucose (sugar) levels. Research studies in the United States and abroad have found that improved glycemic control benefits people with either type I or type II diabetes. In general, for every 1 percent reduction in A1c, the relative risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent. The American Diabetes Association recommends an A1c of less than 7 percent. Patients with poorly controlled diabetes (A1c greater than 9 percent) are at higher risk of developing diabetic complications. Measuring A1c assesses the effectiveness of therapy. For this indicator, low scores indicate better compliance. Table 15 displays the scores of the parent facility and the Belton and Nevada CBOCs.

Measure	Meets Target	Facility	Qtr3 Numerator	Qtr 3 Denominator	Qtr 3 (%)
DM –A1c > 9 or not done in past year	19%	589 Kansas City VAMC	14	62	**21**
		589GB Belton CBOC	2	45	**4**
		589GD Nevada CBOC	6	42	**14**

Table 15. A1c Testing, FY 2010

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women 40 and older. Comparison of the Belton and Nevada CBOCs to the parent facility's breast cancer screening is listed in Table 16.

Measure	Meets Target	Facility	Qtr 3 Numerator	Qtr 3 Denominator	Qtr 3 (%)
Mammography, 50-69 years old	77%	589 Kansas City VAMC	22	31	**70**
		589GB Belton CBOC	8	12	**67**
		589GD Nevada CBOC	11	26	**42**

Table 16. Women's Health, FY 2010

The facility recently centralized the mammography ordering process and designated staff to track the results of ordered mammograms. This should increase the documentation of the results of completed mammograms.

C&P

We reviewed the C&P files of two providers and the personnel folders of two nurses at the Belton CBOC and three providers and two nurses at the Nevada CBOC. All providers possessed a full, active, current, and unrestricted license; and privileges were appropriate for services rendered. All nurses' license and education requirements were verified and documented. However, we found the following areas that required improvement:

OPPE

Service-specific criteria for OPPE had been developed and approved. At the Belton and Nevada CBOCs, we found evidence that the facility compared practitioner data either to those practitioners doing similar procedures or to aggregated data of those privileged practitioners with the same or comparable privileges. We found sufficient performance data to meet current requirements. However, documentation of the service chief's assessment of that data was not completed according to facility policy. The OPPE assessments were not completed in the required timeframe and did not consistently include dates, recommendations, and proof that privileges were reviewed at the service chief level.

Documentation of Privileging Decisions

ECMS meeting minutes did not include documentation of the review or approval of PSB privileging or re-privileging recommendations prior to granting privileges to the providers at the Belton and Nevada CBOCs. VHA policy requires that request for privileges, along with the appointment recommendation of the PSB, must be submitted to the ECMS for review. The ECMS then evaluates the applicant's credentials to determine if clinical competence is adequately demonstrated to support the granting of privileges. ECMS minutes must reflect documents reviewed and the rationale for decision. The ECMS then submits a final recommendation to the Facility Director.[11] The same documentation is required for providers seeking re-privileging.

Recommendation 11. We recommended that the service chief complete the OPPE assessments, according to facility policy, for providers at both the Belton and Nevada CBOCs.

Recommendation 12. We recommended that the PSB submit appointment recommendations to ECMS.

Recommendation 13. We recommended that the ECMS meeting minutes include documents reviewed and the rationale for the recommendation decision.

[11] VHA Handbook 1100.19.

Management of Laboratory Results

VHA Directive 2009-019 requires critical test results to be communicated to the ordering provider or surrogate provider within a timeframe that allows for prompt attention and appropriate clinical action to be taken. VHA also requires that the ordering provider communicate test results to patients so that they may participate in health care decisions. Each parent facility is required to develop a written policy for communicating test results to providers and documenting communications in the medical record, to include a system for surrogate providers to receive results when the ordering provider is not available. In addition, ordering providers are required to communicate outpatient test results (those not requiring immediate attention) to patients no later than 14 calendar days from the date on which the results are available to the ordering provider.

We reviewed the parent facility's policies and procedures and the medical records of patients who had tests resulting in critical values and normal values. We found the following, with one process that needed improvement.

Critical Laboratory Results

We found that the Belton and Nevada CBOCs had effective processes in place to communicate critical laboratory test results to ordering providers and patients. We reviewed the medical records of 13 patients (3 at Belton and 10 at Nevada) who had critical laboratory results and found that 12 (92 percent) records contained documented evidence of patient notification and follow-up actions.

Normal Laboratory Results

We found that the Belton CBOC did not have processes in place to communicate normal laboratory test results to patients. We reviewed the medical records of 20 patients (10 at the Belton CBOC and 10 at the Nevada CBOC) and found evidence that the Belton CBOC had not communicated normal results to 3 (30 percent) of the patients within 14 calendar days from the date the results were available to the ordering provider. All 10 patients at the Nevada CBOC had results communicated to them within 14 calendar days.

Recommendation 14. We recommended that normal test results be consistently communicated within the specified timeframe to patients at the Belton CBOC.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs were generally clean. However, we found the following areas that needed improvement.

Hand Hygiene Monitor

At the Belton and Nevada CBOCs, we found no documentation that hand hygiene data had been collected during FY 2010 through 1st Qtr, FY 2011. Therefore, the facility could not conduct the appropriate data analysis or identify any trends. The CDC recommends that healthcare facilities develop a comprehensive hand hygiene program, which includes monitors, data analysis, and provider feedback. The intent is to foster a culture of hand hygiene compliance that promotes IC.

IT Security

At both CBOCs we found rooms containing IT equipment unlocked, and we did not find sign-in/out logs to track individuals who accessed the IT areas. VA Handbook 6500[12] requires that access to areas that contain equipment or information critical to IT infrastructure be limited to authorized personnel. The entrance doors to these areas shall remain locked, unless necessary to open for deliveries or maintenance of equipment, and all entrances to sensitive areas will have a sign-in/out log for tracking individuals entering these areas. Unlocked entrance doors and lack of oversight for IT access could lead to potential loss of secure information.

Safety and Fire Inspections

We found no documentation of safety and fire inspections for the past 2 years at the Nevada CBOC. According to facility policy, the Safety Office is responsible for ensuring that the inspections will be conducted. Without documented evidence of the inspections, management is not able to determine compliance with safety standards and facility safety rules and not able to identify unsafe practices and procedures.

Physical Access

We observed a patient, using a motorized wheelchair, encounter difficulty leaving the Belton CBOC. The ramp for the handicap parking space located in front of the clinic was obstructed by snow and ice. In addition, the automatic door opener for handicap patients was located at the clinic's back entrance, but there was no designated handicap parking space in the back parking lot.

Life Safety

The Belton CBOC had two front clinic doors locked when patients were present, and both doors had signage indicating they were to remain unlocked when the building was occupied. We found one emergency exit door, located in the back of the clinic, obstructed by snow. OSHA requires that exit routes must be free and unobstructed.

[12] VA Handbook 6500, *Information Security Program*, September 18, 2007.

PII

At the Belton CBOC public restroom, we found a laboratory specimen labeled with a patient's name and SSN. When we interviewed staff, we determined that the normal process for submitting laboratory specimens was to leave them in the public restroom until collected by CBOC staff. Because the room was accessible to the public, patients' PII was at risk. According to HIPAA regulations, control of the environment includes control of confidential patient information; therefore, patients' PII should be protected from unauthorized disclosure.

Recommendation 15. We recommended that hand hygiene data be collected, analyzed, and reported to providers at the Belton and Nevada CBOCs.

Recommendation 16. We recommended that the Chief of OI&T evaluate identified IT security vulnerabilities at the Belton and Nevada CBOCs and implement appropriate IT security measures to ensure compliance with VA Handbook 6500.

Recommendation 17. We recommended that the facility Safety Office ensure that the annual safety and fire inspections are conducted according to local policy at the Nevada CBOC.

Recommendation 18. We recommended that access for disabled veterans be improved at the Belton CBOC.

Recommendation 19. We recommended that exit routes remain free and unobstructed at the Belton CBOC.

Recommendation 20. We recommended that all PII be secured and protected at the Belton CBOC.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies, including MH, are handled. We found the following areas that needed improvement.

Maintenance of AEDs

AEDs at the Belton and Nevada CBOC received preventive maintenance annually. However, the facility policy requires that AEDs receive preventive maintenance every 6 months. If equipment does not receive the required maintenance, then it could potentially fail when needed.

Recommendation 21. We recommended that the AEDs receive preventive maintenance every 6 months as required by facility policy at the Belton and Nevada CBOCs.

E. VISN 21, VA Palo Alto HCS – Capitola and Stockton

CBOC Characteristics

Table 17 shows the characteristics of the Capitola and Stockton CBOCs.

CBOC Characteristics	Capitola	Stockton
Type of CBOC	VA Staffed	VA Staffed
Number of Uniques, FY 2010	1,006	6,629
Number of Visits, FY 2010	2,047	27,145
CBOC Size	Small	Large
Locality	Urban	Rural
FTE Provider(s)	1.05	7.15
Type Providers Assigned	Internal Medicine Physician NP Psychiatrist	Internal Medicine Physician PCP NP Psychiatrist Psychologist LCSW Clinical Pharmacist Behavioral Health Technician
Ancillary Staff Assigned	RN	RN LPN Pharmacist Social Worker Phlebotomist
Type of MH Providers	Psychiatrist NP/Clinical Nurse Specialist PCP	Psychologist Psychiatrist LCSW Addiction Counselor
Provides MH Services	Yes	Yes
• **Evening Hours**	No	Yes
• **Weekends**	No	No
• **Plan for Emergencies Outside of Business Hours**	Yes	Yes
• **Provided Onsite**	Medication assessments and follow-up	Substance Use Disorder PTSD MST Homelessness Family Therapy
• **Referrals**	Another VA facility	Another VA facility Non-VA fee-basis or contract
• **Tele-Mental Health Services**	No	Yes (medication management, individual and group therapy)
Specialty Care Services Onsite	No	No
• **Referrals**	Another VA facility	Another VA facility Non-VA fee-basis or contract
Ancillary Services Provided Onsite	EKG Glucose Monitoring	Laboratory EKG
Miles to Parent Facility	45	80

Table 17. CBOC Characteristics

Quality of Care Measures

DM

Diabetes is the leading cause of new cases of blindness among adults age 20−74, and diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50−60 percent. Table 18 displays the parent facility and the Capitola and Stockton CBOCs' compliance in screening for retinopathy.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM – Retinal Eye Exam	70%	640 VA Palo Alto HCS	111	123	90
		640GA Capitola CBOC	19	25	76
		640HA Stockton CBOC	39	50	78

Table 18. Retinal Exam, FY 2010

A1c is a blood test that measures average blood glucose (sugar) levels. Research studies in the United States and abroad have found that improved glycemic control benefits people with either type I or type II diabetes. In general, for every 1 percent reduction in A1c, the relative risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent. The American Diabetes Association recommends an A1c of less than 7 percent. Patients with poorly controlled diabetes (A1c greater than 9 percent) are at higher risk of developing diabetic complications. Measuring A1c assesses the effectiveness of therapy. For this indicator, low scores indicate better compliance. Table 19 displays the scores of the parent facility and the Capitola and Stockton CBOCs.

Measure	*Meets Target*	*Facility*	*Qtr3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
DM –A1c > 9 or not done in past year	25%	640 VA Palo Alto HCS	22	123	17
		640GA Capitola CBOC	2	25	8
		640HA Stockton CBOC	4	50	8

Table 19. A1c Testing, FY 2010

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women 40 and older. Comparisons of the Capitola and Stockton CBOCs to the parent facility's breast cancer screening are listed in Table 20.

Measure	*Meets Target*	*Facility*	*Qtr 3 Numerator*	*Qtr 3 Denominator*	*Qtr 3 (%)*
Mammography, 50-69 years old	77%	640 VA Palo Alto HCS	44	57	79
		640GA Capitola CBOC	2	3	67
		640HA Stockton CBOC	19	30	63

Table 20. Women's Health, FY 2010

Inquiries into the Capitola and Stockton CBOCs' low scores revealed that mammograms were obtained for the patients through a fee basis agreement. Managers reported that the patients either did not schedule an appointment after the fee basis was approved or did not keep the scheduled appointment. The facility's Women's Heath Medical Director submitted an action plan outlining an approach for increasing compliance. The plan includes several interventions such as verbal patient education, provider education, and reminder letters or phone calls to patients.

C&P

We reviewed the C&P files of three providers and the personnel folders of two nurses at the Capitola CBOC and five providers and four nurses at the Stockton CBOC. All providers possessed a full, active, current, and unrestricted license; and privileges were appropriate for services rendered. All nurses' license and education requirements were verified and documented. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. OPPE included minimum competency criteria for privileges.

Management of Laboratory Results

VHA Directive 2009-019 requires critical test results to be communicated to the ordering provider or surrogate provider within a timeframe that allows for prompt attention and appropriate clinical action to be taken. VHA also requires that the ordering provider communicate test results to patients so that they may participate in health care decisions. Each parent facility is required to develop a written policy for communicating test results to providers and documenting communications in the medical record, to include a system for surrogate providers to receive results when the ordering provider is not available. In addition, ordering providers are required to communicate outpatient test results (those not requiring immediate attention) to patients no later than 14 calendar days from the date on which the results are available to the ordering provider.

We reviewed the parent facility's policies and procedures and the medical records of patients who had tests resulting in critical values and normal values. We identified the following areas that needed improvement.

Critical Laboratory Results

We found that the Capitola CBOC did not have effective processes in place to communicate critical laboratory test results to patients. We reviewed the medical

records of 15 patients (5 at the Capitola CBOC and 10 at the Stockton CBOC) who had critical laboratory results and found that 3 (60 percent) of Capitola CBOC records contained documented evidence of patient notification and follow-up actions. Patients who had critical laboratory results at the Stockton CBOC were notified of their test results and provided appropriate follow-up instructions.

Recommendation 22. We recommended that the ordering providers document patient notification and treatment actions in response to critical test results at the Capitola CBOC.

Normal Laboratory Results

We found that the Stockton CBOC did not have consistent processes in place to communicate normal laboratory test results to patients. We reviewed the medical records of 17 patients (7 at the Capitola CBOC and 10 at the Stockton CBOC) and determined that the Stockton CBOC had not communicated normal test results to 5 (50 percent) of the patients within 14 calendar days from the date the results were available to the ordering provider. All patients at the Capitola CBOC had results communicated to them within 14 calendar days.

Recommendation 23. We recommended that normal test results at the Stockton CBOC be communicated to patients within the specified timeframe.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs met most standards, and the environments were generally clean and safe. However, we found the following area that needed improvement:

Hand Hygiene

The Capitola CBOC initiated hand hygiene monitors and data collection 1 month prior to our on-site visit. The JC, National Patient Safety Goals, and CDC[13] recommend that healthcare facilities develop a comprehensive IC program with a hand hygiene component that includes monitors, data analysis, and provider feedback. The intent is to foster a culture of hand hygiene compliance that ensures the control of infectious diseases.

Recommendation 24. We recommended that hand hygiene data is consistently collected, measured, and analyzed at the Capitola CBOC.

[13] CDC is one of the components of the Department of Health and Human Services that is responsible for health promotion; prevention of disease, injury and disability; and preparedness for new health threats.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies, including MH, are handled. Both CBOCs had policies that outlined management of medical and MH emergencies. Our interviews revealed staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

VISN 4 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 12, 2011

From: Director, VISN 4 (10N4)

Subject: CBOC Review: Georgetown, DE and Ventnor, NJ

To: Director, Baltimore Healthcare Inspections Division (54BA)

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

1. I have reviewed the responses provided by the Wilmington VAMC and I am submitting it to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:

MICHAEL E. MORELAND, FACHE

Wilmington VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 11, 2011

From: Director, Wilmington VAMC (460/00)

Subject: CBOC Review: Georgetown, DE and Ventnor, NJ

To: Director, VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General's CBOC Reviews: Georgetown, DE and Ventnor, NJ. We concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(original signed by:)

CHARLES M. DORMAN, FACHE
Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the PSB grant privileges appropriate for the services provided at the Georgetown and Ventnor CBOCs.

Concur

Target date for completion: July 1, 2011

The privilege delineations for the CBOC physicians will be revised to reflect privileges specific and appropriate for the CBOC practice setting. The facility Credentialing and Privileging office is actively reviewing current privileges for all CBOC providers with the responsible Service Chief. The proposed changes will be submitted to the next Medical Executive Board for approval.

Recommendation 2. We recommended that facility managers improve processes to communicate normal test results to patients and monitor compliance at the Georgetown CBOC.

Concur

Target date for completion: July 1, 2011

Facility is converting the Standard Operating Procedure on Normal Test Results, to a Medical Center Memorandum to strengthen accountability and enhance communication and documentation of the required reporting process to meet VHA Directive 2009-019. The new Center Memorandum will enhance performance monitoring. Results will be tracked by the Medical Record Council. Additionally, instances of non compliance will be reported to Service Chiefs. The Center Memorandum is being routed through the facility Center Memorandum process for review and concurrence.

VISN 8 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2011

From: Director, VISN 8 (10N8)

Subject: CBOC Reviews: Guayama and Ponce, PR

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed and concur with the findings and recommendations contained in the Healthcare Inspection report, as it relates to the Community Based Outpatient Clinics Review in Guayama and Ponce, Puerto Rico conducted on February 7-11, 2011.

2. Appropriate action has been initiated and/or completed, as detailed in the attached report.

Nevin M. Weaver

Nevin M. Weaver, FACHE
Network Director, VISN 8

VA Caribbean HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 13, 2011

From: Director, VA Caribbean HCS (672/00)

Subject: CBOC Reviews: Guayama and Ponce, PR

To: Director, VISN 8 (10N8)

1. On behalf of the VA Caribbean Healthcare System, I want to express my appreciation to the Office of Inspector General (OIG), Office of Healthcare Inspections for their professional and comprehensive Community Based Outpatient Clinics Review in Guayama and Ponce, Puerto Rico conducted on February 07-11, 2011.

2. I concur with the findings and recommendations of this Office of Inspector General report. The VA Caribbean Healthcare System welcomes the external perspective provided by this report.

3. The attached outlines the actions taken by the VA Caribbean Healthcare System in response to the OIG findings.

Wanda Mims, MBA

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 3. We recommended that providers use the template required by local policy to document communication of critical laboratory results at the Guayama and Ponce CBOCs.

Concur

Target date for completion: May 2011

Refresher training on the Center Memorandum on "Critical Tests and Critical Values Results" 00-09-68 and training on the newly published Center Memorandum on the Ordering and Reporting Test Results will be provided to providers by May 2011. This training includes the expectation that providers consistently use the required template. Ongoing compliance will be monitored by the Quality Management Office and be reported to ACOS for Primary Care, the Patient Safety Committee and to the Clinical Executive Board.

Recommendation 4. We recommended that normal test results be communicated to patients within the specified timeframe at the Guayama CBOC.

Concur

Target date for completion: May 2011

Refresher training on the Center Memorandum on "Critical Tests and Critical Values Results" 00-09-68 and training on the newly published Center Memorandum on the Ordering and Reporting Test Results will be provided to providers by May 2011. For critical tests and critical value results direct telephone contact is made to patients. For routine lab work, patient appointments and corresponding lab work will be coordinated within fourteen days of patient's next appointment with provider. For cases in which patients miss their appointments, test results will be communicated by mail, secure messaging or telephone call and documented accordingly. Ongoing compliance will be monitored by the Quality Management Office and be reported to ACOS for Primary Care, the Patient Safety Committee and to the Clinical Executive Board.

Recommendation 5. We recommended that the local policy define how medical emergencies, including the use of equipment and medications, are to be managed at the Ponce CBOC, and educate staff accordingly.

Concur

Target date for completion: May 2011

A standard operating procedure is currently established which defines how medical emergencies, including the use of equipment and medications, are to be managed at the Ponce OPC. A local Center Memorandum on the management of medical emergencies at the Outpatient Clinics is being established to standardize practices. This memorandum will be completed and implemented by May 2011.

VISN 11 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 13, 2011

From: Director, Veterans in Partnership (10N11)

Subject: CBOC Reviews: Goshen, IN

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

Attached please find the response from NIHCS on the review of the Goshen, IN CBOC. If you have any questions please contact Kelley Sermak, Acting QMO VISN 11, at 734-222-4302.

Michael S. Finegan

VA Northern Indiana HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 12, 2011

From: Director, VA Northern Indiana HCS (610/00)

Subject: CBOC Reviews: Goshen, IN

To: Director, Veterans in Partnership (10N11)

If additional information is required, please contact Barbara Lyons, Quality Manager at 765-674-3321, extension 76116.

Daniel D. Hendee, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 6. We recommended that employees receive BLS training within the timeframe specified in facility policy at the Goshen CBOC.

Concur

Target date for completion: April 22, 2011

A revised orientation checklist has been developed to include BLS training. A change has been implemented to have staff BLS certification prior to their hire date.

The CBOC Coordinator will track those staff members who are due for renewals. This report will be generated on a monthly basis.

Recommendation 7. We recommended that the staff ensure that the auditory privacy zone is maintained during the check-in process at the Goshen CBOC.

Concur

Target date for completion: February 8, 2011

Staff have been trained to follow the process of having patients stand behind the posted sign, which is the designated zone of privacy. This training was completed on February 8, 2011.

Recommendation 8. We recommended that the COTR develop a process to validate the prorated capitated rate calculation submitted by the contractor on the monthly invoice.

Concur

Target date for completion: April 22, 2011

A process was developed February 9, 2011 to validate prorated capitated rate calculation submitted by the contractor on the monthly invoice and it is currently in place. Verification began February 9, 2011 and will continue to be completed monthly.

Recommendation 9. We recommended that the VANIHCS Director determine the total amount of overpayments to the contractor during the contract period as a result of ineligible enrollees and, with the assistance of the Regional Counsel, assess the collectability of the overpayment.

Concur

Target date for completion: May 11, 2011

Facility COTR implemented a new verification process in late August 2010 and was able to get it modified in time for the October 2010 invoice. The new process allows for the verification of enrollment status for all Veterans, including the validation of all billable patients.

An audit was conducted from April through September 2010. The findings of the audit concluded that a Bill of Collection be sent to the Contractor in the amount of $3,262.04. This bill was sent on April 11, 2011.

Recommendation 10. We recommended that the VANIHCS Director comply with the contract terms, specifically that the VA maintain the authority to end enrollment of patients.

Concur

Target date for completion: May 31, 2011

VANIHCS has sole authority to enroll and end enrollment of patients at the CBOC. The CBOC staff will be educated about the enrollment/end of enrollment process. A quarterly review will be conducted and maintained on file.

VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 14, 2011

From: Director, VISN 15 (10N15)

Subject: CBOC Review: Belton and Nevada, MO

To: Director, Kansas City Healthcare Inspections Division (54KC)

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

I have reviewed the recommendations and concur with the responses and action plans. If you have any questions, please contact our office at 816.701.3000.

(original signed by:)
JAMES R. FLOYD, FACHE
Director, VA Heartland Network (10N15)

Kansas City VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 14, 2011

From: Director, Kansas City VAMC (589/00)

Subject: CBOC Review: Belton and Nevada, MO

To: Director, VISN 15 (10N15)

Attached, please find the responses to the OIG report.

(original signed by:)
KENT HILL
Director, Kansas City VA Medical Center

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 11. We recommended that the service chief complete the OPPE forms, according to facility policy, for providers at both the Belton and Nevada CBOCs.

Concur

Target date for completion: **Recommend this item be closed.**

There were timeliness issues for service lines who did not complete written documentation of their assessments and refer to ECMS timely. Timeliness issues and expectations have been discussed at ECMS and with Service Chiefs by the Chief of Staff. OPPEs are to be completed in writing no later than 3 months post evaluation period. Performance Improvement Staff perform concurrent monitoring for the next 2 consecutive OPPE cycles to assure timely submission and will continue this process as required.

Recommendation 12. We recommended that the PSB submit appointment recommendations to ECMS.

Concur

Target date for completion: **Recommend this item be closed.**

PSB agenda items/actions presented at ECMS. This has been done at ECMS meetings subsequent to the OIG (March and April 2011) and will be an agenda item each month at ECMS.

Recommendation 13. We recommended that the ECMS meeting minutes include documents reviewed and the rationale for the recommendation decision.

Concur

Target date for completion: **Recommend this item be closed.**

PSB agenda items/actions presented at ECMS. This has been done at ECMS meetings subsequent to the OIG (March and April 2011) and will be an agenda item each month at ECMS. Information documented in ECMS minutes.

Recommendation 14. We recommended that normal test results be consistently communicated within the specified timeframe to patients at the Belton CBOC.

Concur

Target date for completion: **September 15, 2011**

In addition to notifying patients of test results face to face during clinic visit and by phone, we have also disseminated a letter template to Primary Care Providers to facilitate notification of test results. In addition, we are in the process of procuring a printer and software, similar to Tampa VA's program, to facilitate mailing lab results to patients on a routine basis. It is our intent to rollout the process facility-wide.

Recommendation 15. We recommended that hand hygiene data be collected, analyzed, and reported to providers at the Belton and Nevada CBOCs.

Concur

Target date for completion: **Recommend this item be closed.**

Initiated January 2011. CBOC staff will monitor hand hygiene on an ongoing basis and report data to the IC Office by the last business day of the month for the reporting month. Nurse Co-leader and Nurse Manager, CBOC will ensure the monthly data reports provided by the IC Office are distributed and discussed at the staff level.

Recommendation 16. We recommended that the Chief of OI&T evaluate identified IT security vulnerabilities at the Belton and Nevada CBOCs and implement appropriate IT security measures to ensure compliance with VA Handbook 6500.

Concur

Target date for completion: **Recommend this item be closed.**

Access Rosters and Sign-Out sheets for the Data Closets at all CBOC's have been posted. Management and CBOC staff support have been requested to ensure strict adherence to guidance.

Recommendation 17. We recommended that the facility Safety Office ensure that the annual safety and fire inspections are conducted according to local policy at the Nevada CBOC.

Concur

Target date for completion: **June 30, 2011**

Nevada fire department contacted and CBOC was put on inspection list and first inspection has already been completed in March 2011.

Recommendation 18. We recommended that access for disabled veterans be improved at the Belton CBOC.

Concur

Target date for completion: **Recommend this item be closed.**

Snow accumulation blocked handicapped access; the contract owner notified immediately and is aware that both handicapped entrances must have snow removal at all times.

Recommendation 19. We recommended that exit routes remain free and unobstructed at the Belton CBOC.

Concur

Target date for completion: **Recommend this item be closed.**

Snow accumulation blocked exit, the contract owner notified immediately and is aware that both exits must have snow removal at all times. Doors will remain unlocked during clinic hours.

Recommendation 20. We recommended that all PII be secured and protected at the Belton CBOC.

Concur

Target date for completion: **Recommend this item be closed.**

Patient had left labeled specimen in public bathroom. Laboratory health technicians now instruct all patients to directly give items to laboratory rather than leaving them in the bathroom.

Recommendation 21. We recommended that the AEDs receive preventive maintenance every 6 months as required by facility policy at the Belton and Nevada CBOCs.

Concur

Target date for completion: **Recommend this item be closed.**

Biomedical engineering to complete preventive maintenance per policy.

VISN 21 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 15, 2011

From: Director, VISN 21 (10N21)

Subject: CBOC Review: Capitola and Stockton, CA

To: Director, Los Angeles Healthcare Inspections Division (54LA)

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

1. Thank you for the opportunity to review the draft OIG report from the site visit that was conducted during the week of February 7, 2011 at the Capitola and Stockton CBOCs which are part of the Palo Alto Health Care System. We concur with the recommendations and will ensure that the actions described in the plan are implemented and effective by the established target dates.

2. If you have any questions regarding the attached response or action for the recommendations please contact Ms Terry Sanders, VISN 21 Associate Quality Management Officer at (707) 562-8370.

(*original signed by:)*

Sheila M. Cullen

Attachments

VA Palo Alto HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 15, 2011

From: Director, VA Palo Alto HCS (640/00)

Subject: CBOC Review: Capitola and Stockton, CA

To: Director, VA Sierra Network (10N21)

1. VAPAHCS appreciates the opportunity to review the OIG Report on the CBOC Review of our Capitola and Stockton CBOCs.

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, feel free to call me at (650) 858-3939.

(*original signed by:)*

Elizabeth Joyce Freeman
Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 22. We recommended that the ordering providers document patient notification and treatment actions in response to critical test results at the Capitola CBOC.

Concur

Target date for completion: June 30, 2011

Capitola staff were not reliably documenting patient notification and follow-up actions for critical laboratory results. Staff education has occurred and staff expressed understanding of the need for improvement. Auditing for compliance with documentation of notification of critical labs in the medical record will occur in 3Q FY11 with a target of 100% compliance.

Recommendation 23. We recommended that normal test results at the Stockton CBOC be communicated to patients within the specified timeframe.

Concur

Target date for completion: September 30, 2011

VAPAHCS currently follows our lab results directive. A Patient Health Journal is shared with the Veteran that includes lab results. Patients are also notified within the 14 day time period by phone and/or letter.

Auditing of compliance will occur using our Ambulatory Care clinical review process. Notification to patients of normal test results is an item that has been added to the review form. This is the same process that is used for medical record compliance and clinical practice guideline compliance. The audit consists of five medical record reviews/provider/quarter. We will continue to audit indefinitely but will report audit findings for the next two quarters to the Medical Executive Board.

Recommendation 24. We recommended that hand hygiene data is consistently collected, measured, and analyzed at the Capitola CBOC.

Concur

Target date for completion: Consider this closed.

Hand hygiene monitoring consistent with the VAPAHCS hand hygiene program was initiated at Capitola CBOC in January, 2011 and continues on a monthly basis. Ten direct observations/month are conducted. The organization-wide target compliance goal for hand hygiene before and after patient contact is 80%.

Capitola CBOC hand hygiene compliance rates for January, February, and March 2011 were 90%, 100%, and 100% respectively. VAPAHCS hand hygiene compliance data is reported to the Environment of Care Committee, Medical Executive Board, Infection Control Committee, and Long Term Care TQI Committee on a quarterly basis.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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