



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 07-01605-186

Combined Assessment Program Review of the VA Central California Health Care System Fresno, California



August 13, 2007

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of May 21–24, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Central California Health Care System (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 132 system employees. The system is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

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

- Staff Satisfaction.
- Community Service.
- Fall Prevention Program.
- Patient Satisfaction.

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

- Document, implement, and evaluate specific corrective actions when problems are identified in QM review areas.
- Document comprehensive adverse event disclosure notes, as appropriate.
- Comply with the Veterans Health Administration's (VHA's) Utilization Management (UM) Policy.
- Review all health information system business rules, and take appropriate actions to ensure compliance with VHA policy.

The system complied with selected standards in the following four activities:

- Environment of Care (EOC).
- Patient Satisfaction Survey Scores.
- Surgical Care Improvement Project.
- Community Based Outpatient Clinic (CBOC).

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

Comments

The VISN and System Directors concurred with the findings and recommendations. (See Appendixes A and B, pages 11–15, for the full text of the Directors' comments.) The action plans are acceptable and have been implemented. We consider all recommendations closed.

(original signed by Dana Moore, Ph.D. for:)

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

Introduction

Profile

Organization. The system is a tertiary facility located in Fresno, CA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two CBOCs in Tulare and Atwater, CA. The system is part of VISN 21 and serves a veteran population of about 115,000 throughout six counties in central California.

Programs. The system provides medical, surgical, behavioral health, dental, geriatric, rehabilitation, and neurology services. The system has 54 hospital beds and 60 nursing home beds.

Affiliations and Research. The system is affiliated with the University of California, San Francisco and provides training for 45 residents, as well as other disciplines, including nursing. In fiscal year (FY) 2005, the system research program had 19 projects and a budget of \$312,000. Important areas of research included diabetes, Alzheimer's disease, and post-traumatic stress disorder.

Resources. In FY 2006, medical care expenditures totaled \$82.5 million. The FY 2007 medical care budget is \$89.8 million. FY 2006 staffing was 792.7 full-time employee equivalents (FTE), including 59.5 physician and 147.4 nursing FTE.

Workload. In FY 2006, the system treated 24,347 unique patients and provided 2,682 inpatient days in the hospital and 460 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 2,642 discharges, and the average daily census, including nursing home patients, was 92. Outpatient workload totaled 244,804 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program

fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

- Business Rules for Veterans Health Information Systems.
- CBOC.
- EOC.
- Patient Satisfaction Survey Scores.
- QM.
- Surgical Care Improvement Project.

The review covered system operations for FY 2006 and FY 2007 through May 18, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Central California Healthcare System, Fresno, California*, Report No. 04-01944-07, October, 22, 2004). We concluded that system managers had implemented the appropriate corrective actions in response to the recommendations.

During this review, we also presented fraud and integrity awareness briefings for 132 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

are implemented. Activities in the “Review Activities without Recommendations” section have no reportable findings.

Organizational Strengths

Staff Satisfaction

The All Employee Surveys conducted in FYs 2004 and 2006 reflected high morale, with scores above the VHA average in 96 percent of measured areas. The system’s senior leaders attributed the high scores, in part, to the implementation of staff development and leadership programs during the past 4 years.

The system reported that they maintained a strong partnership with the American Federation of Government Employees. An innovative staff recognition program has rewarded over 60 percent of the system’s workforce since 2000. In 2006, the system won the VA Under Secretary for Health’s Diversity Award for Workforce Development and Succession Planning and the VA Secretary’s Labor-Management Relations Award.

Community Service

Since 1999, system managers and employees have participated in an annual community food drive for the Fresno Honcho Exchange Labor Program, or H.E.L.P. Also, in 2006, the system was recognized as Large Employer of the Year by the Central Valley Mayor’s Committee for the Partnership and Advocacy of People with Disabilities.

Fall Prevention Program

Beginning in January 2007, system managers implemented an innovative program called “Red Socks for Fall Prevention.” The system submitted a proposal and received a Patient Safety Grant to purchase red non-slip socks. Patients assessed to be at high risk for falling are given the red socks to wear during their stay. The red socks raise staff awareness to help keep patients safe wherever they are in the facility. Evaluation of data in May 2007 showed a 13 percent decrease in falls.

Patient Satisfaction

In 2006, high inpatient satisfaction scores resulted in the system’s ranking of 16th in VHA. System managers attributed this success, in part, to the implementation of efficiencies, such as the electronic health record, filmless imaging, and bar-coded medication administration. Also, since 2005, the “Walk the Talk” program has involved senior

managers interviewing patients, with timely follow-up on any identified issues with unit/clinic managers.

Results

Review Activities with Recommendations

Quality Management

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

The QM program was generally effective in providing oversight of the system's quality of care. Appropriate review structures were in place for 11 of the 14 program activities reviewed. However, we identified three areas that needed improvement.

Action Plans. We found that staff analyzed data in all program areas reviewed. However, we did not find evidence of corrective action plans to address identified problems in several areas, including patient complaints, UM, and medical record reviews.

Adverse Event Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with the patients and, with input from VA Regional Counsel, inform them of their right to file tort or benefits claims. During the period April 2006–April 2007, five patients experienced serious adverse events. Clinicians appropriately documented the adverse event discussions in the progress notes of all five patients. However, only two of the patients were advised of their rights to file a claim. The Chief of QM had identified the problem and had provided training to clinicians in the 2nd quarter of FY 2007.

Utilization Management. Admission and continued stay reviews were performed, but no specific actions were documented when the reviewed cases did not meet criteria. For example, in the 4th quarter of FY 2006, only about 50 percent of the days on the medicine unit met the

continued stay criteria, yet no specific problems were identified, and no action plans were documented.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires that specific corrective actions are documented, implemented, and evaluated when problems are identified in QM review areas.

The VISN and System Directors concurred with the findings and recommendation. As of June 6, a new process for reviewing meeting minutes and tracking action items was implemented. We find the actions acceptable and consider this recommendation closed.

Recommendation 2

We recommended that the VISN Director ensure that the System Director requires that comprehensive adverse event disclosure notes are completed, as appropriate.

The VISN and System Directors concurred with the findings and recommendation. In May 2007, the Chief of Staff reviewed the disclosure policy with the medical staff. The Chief of QM will review all events to determine whether they warrant full disclosure. As of June 6, a process for monitoring disclosure notes was fully implemented. We find the actions acceptable and consider this recommendation closed.

Recommendation 3

We recommended that the VISN Director ensure that the System Director requires compliance with VHA's UM Policy,¹ including referring cases to physician advisors, documenting discussions of the results, and taking actions when appropriate.

The VISN and System Directors concurred with the findings and recommendation. The UM Program Manager will refer cases not meeting the criteria to physician advisors. UM reports will be presented to and acted upon by clinical service chiefs. Summary reports will be presented to the Medical Staff Executive Board (MSEB). As of June 6, all action plans were implemented. We find the action plans acceptable and consider this recommendation closed.

¹ VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005.

Business Rules for Veterans Health Information Systems

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. OI also recommended that the ability to edit signed records be limited to the facility's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and system policies and interviewed the Health Information Management Service (HIMS) Chief and one of the clinical application coordinators (CACs). We reviewed more than 300 business rules and found 3 that allowed CACs to edit signed records, in violation of VHA policy. The HIMS Chief agreed to delete non-compliant business rules.

Recommendation 4

We recommended that the VISN Director ensure that the System Director requires that HIMS staff conduct a comprehensive review of all business rules, delete inappropriate rules, and perform a periodic review of all rules to ensure compliance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. By May 25, HIMS staff had completed an initial review of all business rules and deleted the inappropriate rules. On June 11, they implemented a new process for quarterly review. We find the actions appropriate and consider this recommendation closed.

Review Activities without Recommendations

Environment of Care

The purpose of this review was to determine if the system complied with selected infection control (IC) and drinking water standards and maintained a safe and clean patient care environment.

The IC program was comprehensive. We reviewed policies, and we reviewed 15 medical records of patients with multi-drug resistant organisms. We found that the policies were appropriate and practices concerning electronic clinical postings were in compliance.

We reviewed documents related to the oversight of the drinking water system and inspected the water storage system to determine whether managers had complied with the required safety and security standards. We found that managers performed the required monthly drinking water testing. In March 2006, the Chief of Maintenance and Repair Section conducted a vulnerability assessment of the water system and made recommendations to enhance security. While the majority of the recommended actions had been implemented, we found three that were not addressed until our site visit. These included posting warning signs, securing the water system entry points, and installing concrete barriers to protect the water wells. At the conclusion of our visit, managers had addressed all identified vulnerabilities.

We also inspected selected clinical areas for cleanliness and general maintenance. Overall, we found that the system maintained a safe and clean environment. We made no recommendations.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent to which the system used the results of VHA's patient satisfaction survey to improve care and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The table on the next page shows the national, VISN 21, and the system's Survey of Healthcare Experiences of Patients (SHEP) results.

VA Central California Health Care System												
INPATIENT SHEP RESULTS												
FY 2006 Quarters 3 and 4		Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition		
National		81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11		
VISN		81.7	79.4	90.0	68.10	65.8	77.6+	86.2+	72.4-	69.3		
System		83.9+	83.0+	91.5+	70.2	67.2	79.1	86.2+	75.4	73.7+		
OUTPATIENT SHEP RESULTS												
FY 2007 Quarter 1		Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National		81.0	77.8	94.9	72.7	83.5	75.7	82.0	65.3	82.0	81.1	84.8
VISN		82.8	77.4	95	71.3	83.5	74.3	84.7	72.4	81.4	83.3	83.9
System Clinics		83	73.2	96.4	66.5	79.7	70.3	73.4	74.9	78.8	80.3	83.8
Legend: "+" indicates results that are significantly better than the VHA average												

The system's scores exceeded the national average in all inpatient areas. Managers had implemented action plans to improve satisfaction with outpatient care. We found the action plans acceptable and made no recommendations.

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

Healthcare inspectors evaluated the following VHA performance measures (PMs) for FY 2006 and the 1st quarter of FY 2007:

- Timely administration of prophylactic antibiotics – clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The VHA target was 90 percent.
- Timely discontinuation of prophylactic antibiotics – clinicians should discontinue antibiotics within

24–48 hours after surgery. The VHA target was 87 percent.

- Core body temperature control – for colorectal surgery, clinicians should maintain core temperatures at greater than or equal to 96.8 degrees Fahrenheit in the immediate post-operative period. The VHA target was 70 percent.

Although the system did not meet the established targets for the PMs for FY 2006, managers demonstrated that their actions had resulted in improvement. PM scores for FY 2007 were under review at the time of our visit.

We also reviewed the medical records of 15 patients who had selected colorectal, vascular, or orthopedic surgeries performed during FY 2007. Our review results are displayed in the table below. We found that the system's clinicians either appropriately administered and discontinued antibiotics or documented acceptable clinical reasons when this did not occur. Also, they controlled immediate post-operative body temperature for patients who had colorectal surgery. We made no recommendations.

Antibiotic administered timely	Antibiotic discontinued timely	Core body temperature controlled (colorectal surgery)
100 percent (15/15)	93 percent (14/15)	86 percent (6/7)

Community Based Outpatient Clinic

The purposes of this review were to determine if the Tulare CBOC complied with selected VHA standards, improved patient access, and maintained the same standards of care as the rest of the system for providing mental health services and anticoagulation therapy. We interviewed key personnel and patients and evaluated policies, procedures, and other relevant documents.

We found that the CBOC provided quality care and was compliant with the VHA standards of operation reviewed. The clinic had improved access, timeliness, and convenience of services, and patients were satisfied with all aspects of care. Mental health treatment was provided by clinicians at the CBOC, and the standards of care for providing anticoagulation therapy were the same throughout the system.

Documentation for physician and nurse licenses, background checks, and provider privileging was current and complete.

A facility policy outlined appropriate emergency protocols, and CBOC personnel appeared to be knowledgeable of these procedures. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 20, 2007

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

Subject: Combined Assessment Program Review of the VA
Central California Health Care System, Fresno, CA

To: Director, Los Angeles Regional Office of Healthcare
Inspections (54LA)

Director, Management Review Office (10B5)

1. This is in response to your June 6, 2007, memo requesting an update on the status of the recommendations concerning the Combined Assessment Program (CAP) Review of the VA Central California Health Care System, Fresno, California (Project No. 2007-01605-HI-0318).

2. I am pleased to report that VA Central California Health Care System has completed all of the recommendations in the aforementioned CAP review report. Detailed information on the actions taken to close each recommendation is provided in the attached Implementation Plan and related documents.

3. If you have any questions regarding the attached report, please contact me at 707-562-8350, or Judy Daley, VISN 21 Quality Management Officer, at 775-328-1461.

(original signed by:)
Robert L. Wiebe, M.D.

Attachments

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 14, 2007

From: VA Central California Health Care System Director

Subject: Combined Assessment Program Review of the VA Central California Health Care System, Fresno, CA

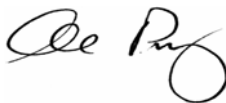
To: Director, Healthcare Inspections Los Angeles Regional Office (54LA)

I wish to thank the OIG CAP Survey Team for their professional, thorough, fair, and instructive survey May 21–24, 2007. I concur with the findings and recommendations. All corrective actions have been implemented and are complete.

I am very pleased with the surveyors' identification of organizational strengths and accomplishments in the following areas: Staff Satisfaction, Community Service, Fall Prevention Program, and Patient Satisfaction. Full compliance with selected standards was noted for: Environment of Care, Patient Satisfaction Survey Scores, Surgical Care Improvement Project, and Community Based Outpatient Clinic.

The VA Central California Health Care System is very proud of the quality patient care that our veterans receive. We are widely recognized as a leader in our community and have partnered with the local community to help feed numerous hungry families. We have a strong commitment to being recognized as a great place to work and volunteer.

Comprehensive surveys, such as the OIG CAP, validate the work and dedication of our employees and help us to maintain our goal of ongoing and continuous readiness.



Alan S. Perry, FACHE
Director

Cc: Director, Management Review Office (10B5)

VA Central California Health Care System, Fresno Response to the Office of Inspector General Combined Assessment Program Review Report

Comments and Implementation Plan

Quality Management

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that specific corrective actions are documented, implemented, and evaluated when problems are identified in QM review areas.

Concur with recommendation.

Planned Actions: A meeting minute and audit/action item template was sent to all Service Chiefs and Secretaries in February 2007 and will be used for documenting findings, actions, and follow-up. These minutes will be sent to Senior Leadership for review. They will be returned to the Service for correction and follow-up if they do not contain proper documentation. An instructional meeting was held on May 18, 2007, as part of the "Closing the Loop on Organizational Improvement Initiatives." Two more meetings in this education series are scheduled for June 15, 2007 and July 27, 2007, facilitated by the QM Department, for all Service Chiefs and Secretaries. A list of action items that have not been closed will be presented to the QM Performance Improvement Board every 6 months for review/recommendation. Action plans will be requested from Services that are not in compliance with reporting and follow-up. The Chief, QM, will review any remaining open items with Senior Leadership every 6 months and at the end of the year. **Closed, June 6, 2007.**

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that comprehensive adverse event disclosure notes are completed, as appropriate

Concur with recommendation.

Planned Actions: In January 2007, a process was developed where the Chief, Medical Records, sends to the Chief, QM, a comprehensive Disclosure of Adverse Events list annually for review. Monthly, the Chief, Medical Records, sends an updated Disclosure of Adverse Events report to the Chief, QM, for review. The Chief, QM, sends this information to the Medical Staff for review. In May of 2007, the Chief, QM, brought the VHA

Disclosure policy to the Chief of Staff meeting for review and discussion. The Medical Staff was reminded of the reporting requirements mandated by the policy. This included review and immediate reporting to the Chief, QM, of any event that warrants formal disclosure to a patient. Ongoing monitoring of disclosure activity will be through the collaborative efforts of the Chief, Medical Records; the Chief, QM; Chief of Staff; and the Medical Staff. Chief, QM, will bring to the Chief of Staff meeting the most current Disclosure Report for review and discussion as a routine reporting agenda item. **Closed June 6, 2007.**

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires compliance with VHA's UM Policy, including referring cases to physician advisors, documenting discussions of the results, and taking actions when appropriate.

Concur with recommendation.

Planned Actions: The Utilization Review Program Manager will facilitate action planning for areas that do not meet Interqual© criteria as a means to ensure compliance. Cases not meeting Criteria will be referred to the physician advisor for appropriate action. Chiefs of Medicine, Surgery, and Psychiatry will review issues pertinent to their Services. Results of those discussions will be noted in monthly and quarterly reports, and action will be taken as appropriate. In February 2007, it was determined that the UM report should be brought to the Performance Improvement Board and the MSEB. The UM report was received at the combined April/May 2007 PI Board Meeting and the Program Manager, as of June 7, 2007, will begin reporting to MSEB as a routine agenda item. **Closed June 6, 2007.**

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that HMS staff conducts a comprehensive review of all business rules, delete inappropriate rules, and perform a periodic review of all rules to ensure compliance with VHA policy.

Concur with recommendation.

Planned Actions: The Chief, Medical Records, and the CACs will complete comprehensive reviews of all business rules. This process has been implemented as of May 25, 2007. Ongoing monitoring will be conducted by the Medical Records Committee as a periodic (annual and quarterly) review beginning June 11, 2007. Business rules that allowed the CACs to delete three specific note types were removed by the Chief, Medical Records, and the Clinical Application Coordinators. The Chief, Medical Records, is now the only person who can alter signed medical records. This action was completed as of May 25, 2007. The Chief,

Medical Records, and the CACs will complete comprehensive periodic reviews of all business rules. This process has been implemented. Monitoring will begin by the Medical Records Committee as a periodic (annual and quarterly) review beginning June 11, 2007. **Closed May 25, 2007.**

OIG Contact and Staff Acknowledgments

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