Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02984-54

Combined Assessment Program Review of the Boise VA Medical Center Boise, Idaho

January 10, 2011

Washington, DC 20420

Why We Did This Review

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

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

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

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
CHF	congestive heart failure
CLC	community living center
CNH	community nursing home
COC	coordination of care
ED	emergency department
EOC	environment of care
facility	Boise VA Medical Center
FTE	full-time employee equivalents
FY	fiscal year
GI	gastrointestinal
HCA	health care agent
HCHV	Health Care for Homeless Veterans
ICU	intensive care unit
JC	Joint Commission
LMS	Learning Management System
MDRO	multidrug-resistant organisms
MEC	Medical Executive Committee
MH	mental health
NIOSH	National Institute for Occupational Safety and Health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PAPR	powered air-purifying respirator
PM	performance measures
PPE	personal protective equipment
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RN	registered nurse
SOPs	standard operating procedures
SW	social worker
TB	tuberculosis
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Boise VA Medical Center, Boise, ID

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of October 18, 2010.

Review Results: The review covered seven activities and one follow-up review area. We made no recommendations in the following activities:

- Management of Test Results
- Medication Management

The facility's reported accomplishments included Health Care for Homeless Veterans Program successes and an Observer Policy that ensures patient care and privacy conform to VA standards.

Recommendations: We made recommendations in the following five activities and in the follow-up review area:

Quality Management: All areas performing moderate sedation need to monitor documentation to ensure completeness.

Physician Credentialing and Privileging: Medical Executive Committee meeting minutes need to consistently include the documents reviewed and the rationale for the reprivileging decision.

Environment of Care: Multi-dose medications need to be dated when opened. Annual N95 respirator fit testing needs to be completed and documented.

Coordination of Care: A process for notifying patients regarding advance directives needs to developed and implemented.

Management of Multidrug-Resistant Organisms: Infection strategies education needs to be provided to patients infected or colonized with multidrug-resistant organisms and their families, and the education needs to be documented.

Contract Community Nursing Home Program: Social workers need to provide the required visits to patients in community nursing homes.

Comments

The Veterans Integrated Service Network and Acting Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area:

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

The review covered facility operations for FY 2009 and FY 2010 through October 21, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Boise Medical Center, Boise, Idaho,*

Report No. 06-02002-233, September 29, 2006). The facility had corrected all prior findings. However, during this review, we identified a finding related to a prior finding in the area of Contract CNH Program monthly visits.

During this review, we also presented crime awareness briefings for 193 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishments

HCHV Program Recognition

In October 2010, the facility was selected as one of 16 sites nationally to participate in VA's 5-year plan to end homelessness. VA based the selection on the facility's highly successful HCHV program and will provide the facility with additional financial support in FY 2011 to develop new initiatives. The HCHV program currently consists of 60 transitional beds, 90 permanent housing units, and 6 emergency beds and offers a full continuum of housing services for veterans. In addition, the facility has established multiple community partnerships that provide additional transitional housing beds and funds to assist with move-in expenses. The distribution of housing vouchers through the U.S. Department of Housing and Urban Development and VA's Supportive Housing Program has increased the number of veterans who successfully obtain resident status. In September 2010, the facility exceeded its target rate of 73 percent by providing housing to 95 percent of its veterans who needed assistance.

Observer Policy and Resident Documentation

The facility implemented the Observer Policy to establish procedures for physician researchers, physician guests, and clinical observers to ensure that the facility conforms to VA standards for patient care and privacy. The facility also implemented an electronic monitoring system to supervise resident physician documentation. As a result, all resident electronic note entries are reviewed by physicians, which provides residents, residency coordinators, and attendees with ongoing feedback.

Results

Review Activities With Recommendations

QM

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

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. However, we identified the following area that needed improvement.

Moderate Sedation. VHA requires facilities to assess and monitor patients undergoing moderate sedation.[1] We reviewed the medical records of 10 patients who underwent moderate sedation and found documentation deficiencies in 3 (30 percent) of the records. Missing elements included immediate assessment prior to sedation and physical assessment.

Recommendation

1. We recommended that all areas performing moderate sedation monitor documentation to ensure completeness.

Physician C&P

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

We reviewed 14 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Reprivileging. VHA requires that requested privileges be presented to the MEC for review along with the supporting clinical competence information and that the documents reviewed and the rationale for the reprivileging decision be documented in the meeting minutes.[2] MEC meeting minutes did not include the required documentation for 5 (36 percent) of the 14 physicians' reviewed.

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Recommendation

2. We recommended that MEC meeting minutes consistently include the documents reviewed and the rationale for the reprivileging decision.

EOC

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

We inspected the medical/surgical, intensive care, MH, and CLC inpatient units; the eye and dental outpatient clinics; and the ED. The facility maintained a generally clean and safe environment. However, we identified the following areas that needed improvement.

Medication Security. Local policy requires that multi-dose medication vials be dated when opened. We found eight open and undated multi-dose medication vials—seven in the eye clinic and one on the medical/surgical unit.

N95 Respirator Fit Testing. CDC guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable swine flu should wear, at a minimum, a fit tested N95 respirator. In addition, OSHA standards require designated staff to be fit tested and trained for respirator use as part of a complete respiratory protection program. We reviewed training records of 21 employees and determined that 5 (24 percent) employees had not received the required annual fit testing.

Recommendations

3. We recommended that multi-dose medications be dated when opened, as required by local policy.

4. We recommended that annual N95 respirator fit testing be completed and documented.

COC

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

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We found the discharge process to be in compliance with VHA policy. However, we identified the following area that needed improvement.

Written Notification Review. VHA requires[3] that patients be given written notification stating their right to accept or refuse medical treatment, to designate an HCA, and to document their treatment preferences in an advance directive. In addition, patients must be informed that VA does not discriminate against patients based on whether or not they have an advance directive. We reviewed advance care planning documentation for 10 patients and determined that the facility had not implemented a process to provide written notification. At the time of this review, a facility team had been organized to correct this deficiency.

Recommendation

5. We recommended that a process for notifying patients regarding advance directives be developed and implemented.

Management of MDRO

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

We inspected the medical/surgical inpatient units and the CLC units and interviewed employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[4] with MDRO and their families receive education on infection reduction strategies, such as hand washing and the proper use of PPE. We reviewed 30 medical records and found that 8 (27 percent) of the records did not have documented evidence of MDRO education.

Recommendation

6. We recommended that infection strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

Contract CNH Program

The prior CAP review findings regarding the Contract CNH Program were corrected. However, we identified a related finding.

Monthly Visits. VHA policy requires an SW or RN to alternately visit each VA patient in a CNH at least every 30 days unless otherwise indicated by the patient's treatment

[3] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[4] Colonization is the presence of bacteria in the body without causing clinical infection.

plan.[5] These follow-up visits are necessary to ensure that treatment goals are being met and that the patient care provided is appropriate. We reviewed 10 medical records (timeframe of August 2009 through September 2010) and found that SWs did not consistently document the required monthly visits in 2 (20 percent) of the records.

Recommendation

7. We recommended that SWs provide the required visits to patients in CNHs.

Review Activities Without Recommendations

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[6]

We reviewed the facility's policies and procedures, the process for monitoring communication of test results, and the medical records of patients who had tests resulting in critical values and normal values. We determined that the facility had implemented an effective reporting process for test results. We made no recommendations.

Medication Management

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

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

Comments

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

[5] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[6] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.

Facility Profile[7]		
Type of Organization	Primary and secondary medical center with some tertiary services	
Complexity Level	2	
VISN	20	
CBOCs	Caldwell, ID Twin Falls, ID	
Veteran Population in Catchment Area	98,000	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	55	
• **CLC/Nursing Home Care Unit**	24	
Medical School Affiliation(s)	University of Washington	
• **Number of Residents**	18	
	Current FY (through June 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$152.7	$134.7
• **Medical Care Expenditures**	$160	$142
Total Medical Care FTE	980	900
Workload:		
• **Number of Station Level Unique Patients**	23,198	22,170
• **Inpatient Days of Care:**		
o **Acute Care**	10,995	13,112
o **CLC/Nursing Home Care Unit**	6,659	5,710
Hospital Discharges	2,665	3,324
Total Average Daily Census (including all bed types)	65	66
Cumulative Occupancy Rate	82 percent	76 percent
Outpatient Visits	213,565	213,736

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Fully inform patients who experience adverse events, and document the discussions.	Adverse events are disclosed to patients as required.	Y	N
2. Provide detailed analyses of UM data.	Detailed analyses of UM data is provided by the Utilization Coordinator.	Y	N
3. Act on results that do not meet goals.	Results that do not meet goals are acted on in a discussion forum.	Y	N
EOC			
4. Secure patient information, hard copy or visible on computer screens.	Patient information is secured by locking equipment and privacy shields for computer monitors.	Y	N
5. Comply with fire safety requirements for storage areas.	Storage areas are routinely monitored for compliance during EOC rounds.	Y	N
Contract CNH Program			
6. Develop individualized plans for follow-up visits prior to placement of patients in CNHs.	Individualized plans and follow-up visit schedules are developed.	Y	N
7. Provide the required RN visits.	RNs provide the required visits.	Y	N
8. Integrate the CNH program into the QM program.	Results of the Quality Assurance Surveillance Plan, including CNH oversight, are reported to the MEC annually.	Y	N
9. Create a CNH Oversight Committee with the appropriate membership.	CNH Oversight Committee with appropriate membership was created.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
10. Contact the State Ombudsman's office annually to discuss issues relevant to the CNH program.	CNH Coordinator contacts the State Ombudsman's office annually.	Y	N
Breast Cancer Management			
11. Take action to improve compliance with VHA's breast cancer screening performance measure.	The facility Breast Cancer Screening PM score of 85 percent in FY 2010 exceeded the target of 72 percent.	Y	N

VHA Satisfaction Surveys

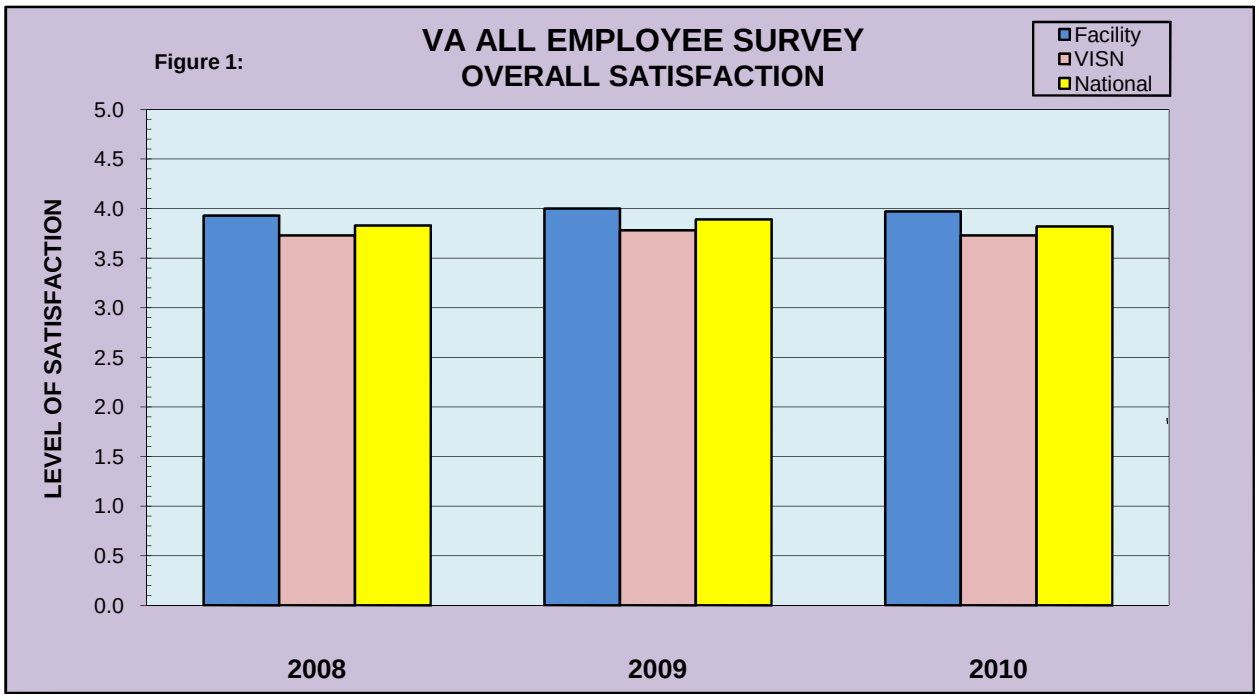
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	71.8	64.0	81.7	64.4	57.5	60.5
VISN	61.2	65.7	68.8	49.6	49.7	50.0
VHA	63.3	63.9	64.5	54.7	55.2	54.8

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[8] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.77	9.26	13.72	20.73	23.5	14.44
VHA	13.31	9.73	15.08	20.57	21.71	15.85

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 9, 2010

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

1. Thank you for the opportunity to provide a review of the draft OIG Report of the *Combined Assessment Program Review of the Boise VA Medical Center, Boise, Idaho.*

2. Attached, please find the facility concurrences and responses to each of the findings from the review conducted the week of October 18, 2010.

3. If you have additional questions or need further information, please contact Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949 or Susan Gilbert, Survey Coordinator, VISN 20 at (360)-567-4678.

Susan Pendergrass, DrPH
Director, Northwest Network (10N20)

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 9, 2010

From: Acting Director, Boise VA Medical Center (531/00)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Director, Northwest Network (10N20)

1. I would like to express my sincere appreciation to the OIG CAP review team for their professionalism and consultative feedback to our employees during our review.

2. I have reviewed the recommendations and concur with the findings. Our comments and planned actions are outlined below.

3. If you have questions or require additional information, please do not hesitate to contact Jan Gieselman, Accreditation Manager, at (208) 422-1000, Extension 7000.

Grant Ragsdale
Acting Director, Boise VA Medical Center

Comments to Office of Inspector General's Report

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

OIG Recommendations.

Recommendation 1. We recommended that all areas performing moderate sedation monitor documentation to ensure completeness.

Concur

Target date for completion: Completed December 7, 2010

The OIG CAP Team noted that not all areas performing moderate sedation were included in the current moderate sedation monitor being performed by the organization. To address this, the organization has adjusted the moderate sedation monitor to include a representative sample of cases from all areas performing moderate sedation (ICU, ED, GI Endoscopy, and Bronchoscopy) to create a total sample size of 70 Moderate Sedation records quarterly. The monitor includes review for documented physical assessment and reassessment immediately prior to sedation. The monitor plan provides for submission of results to the Moderate Sedation Provider's Service Chief for incorporation into provider OPPE data.

Recommendation 2. We recommended that MEC meeting minutes consistently include the documents reviewed and the rationale for the reprivileging decision.

Concur

Target date for completion: The templates will be initiated at the December 16, 2010 MEC meeting.

A report template has been developed for the Service Chief to use when presenting criteria for reprivileging to MEC. The report template reminds the Service Chief to discuss documents reviewed and the rationale for the privileges being requested. A companion template has been developed for the MEC Credentialing/Privileging minutes that includes fields to incorporate supporting clinical competence information and the rationale for the reprivileging decision. The use of these two templates will assure that the required elements are presented during the reprivileging session and are documented in the minutes.

Recommendation 3. We recommended that multi-dose medications be dated when opened, as required by local policy.

Concur

Target date for completion: December 8, 2010 audit results indicate 100 percent compliance. We anticipate continued 90 percent or greater compliance through March 31, 2011.

To address this finding, Pharmacy re-educated staff of the Eye Clinic and 2MS to the facility multidose labeling process and verified that a current supply of the standard labels were available for staff use. A monthly audit has been implemented to identify any opened mutidose vials that are not dated and labeled in accordance with facility policy. Audit results are reported by Pharmacy to the Quality Oversight Council until 4 consecutive months of 90 percent or greater compliance is achieved.

Recommendation 4. We recommended that annual N95 respirator fit testing be completed and documented.

Concur. All personnel who need protection from exposure to respiratory hazards (per OSHA Respiratory Protection Program Guidelines) will be fit tested and trained in the proper use and care of a respirator upon hire and annually thereafter, in accordance with OSHA regulations.

Target date for completion: March 31, 2011, for all delinquent staff to complete annual respirator fit-testing and training, with a documented record of completion.

1. The Industrial Hygienist has notified all employees (and their supervisor) who are delinquent for their annual fit-testing and training.

2. The Industrial Hygienist utilizes OSHA-compliant protocols to complete the annual fit-testing and training required of the facility respiratory protection program.

3. Completion of mandatory fit-testing and training is documented using facility tracking systems.

4. Compliance reports are given to the Environment of Care Committee monthly until 90 percent or greater compliance is achieved (anticipate closure by March 31, 2011). To assure sustained performance, the Industrial Hygienist will provide ongoing quarterly compliance reports for respirator fit-testing and training to the Environment of Care Committee. The Environment of Care Committee takes action for non-compliance.

Recommendation 5. We recommended that a process for notifying patients regarding advance directives be developed and implemented.

Concur

Target date for completion: Completed December 6, 2010.

An ad hoc team of the Integrated Ethics Committee has developed a process for notifying patients regarding advance directives. VA form 10-0137A, "Your Rights Regarding Advance Directives," has been incorporated into the admission packets for the medical center. Documentation templates have been amended to facilitate documentation of the provision of notification related to advance directives into the medical record. Staff have been educated to the notification process and the documentation template revisions. Compliance with the Advance Directive notification process is now a part of the facility Medical Record Review process.

Recommendation 6. We recommended that infection strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

Concur

Target date for completion: We anticipate 90 percent or greater compliance by March 30, 2011.

Staff have been educated to the need to provide infection strategies education to patients the families of patients infected or colonized with MDRO. Educational pamphlets are widely available throughout the medical center. A monitor has been established to review 30 records (or 100 percent if less than 30) of patients newly identified as infected or colonized with MDROs monthly for documentation of MDRO infection control education. Results are reported to Infection Control Committee monthly until 90 percent or greater compliance is achieved for 4 consecutive months. Results will then be reported quarterly for the remainder of FY11, at which time the need to continue the monitor will be re-evaluated. The Infection Control Committee will take action whenever there is reported compliance of less than 90 percent.

Recommendation 7. We recommended that SWs provide the required visits to patients in CNHs.

Concur

Target date for completion: We anticipate 4 consecutive months of compliance by February 28, 2011.

The CNH staff have been re-educated to the handbook requirement for SW or RN to visit each VA patient in a CNH every 30 days unless otherwise indicated by the patient's treatment plan. The Chair of the CNH Oversight Committee monitors 30 records (or 100 percent if less than 30) monthly for documentation of the required CNH RN or SW visit. Results are reported to the Quality Oversight Council until 100 percent compliance is achieved for 4 consecutive months. Results will be monitored and reported quarterly (on an ongoing basis) to the CNH Oversight Committee to assure sustained compliance. The November 2010 audit indicated that 100 percent (35/35) of required RN or SW visits were completed.

OIG Contact and Staff Acknowledgments

Contact	Virginia L. Solana, Director, RN, MA Denver Office of Healthcare Inspections
Contributors	Clarissa B. Reynolds, CNHA, Team Leader Sheila J. Bezak, MBI Katharine L. Foster, RN, BSN Stephanie B. Hensel, JD, MPA, BSN Barry L. Simon, VMD Ann Ver Linden, RN, BSN Cheryl A. Walker, MSN, FNP-C Laura L. Dulcie, BSEE Darrin Gilbert, Resident Agent in Charge, Office of Investigations
Report Preparation	Produced under the direction of Virginia L. Solana Director, Denver Office of Healthcare Inspections

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Northwest Network (10N20)
Director, Boise VA Medical Center (531/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mike Crapo, James E. Risch
U.S. House of Representatives: Raul Labrador, Mike Simpson

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