



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

Office of Healthcare Inspections

Report No. 07-03174-184

Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut



August 13, 2008

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 June 9–13, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Connecticut Healthcare System (the system), West Haven, CT. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training for 314 system employees. The system is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

The CAP review covered five operational activities and assessed compliance with recommendations made during the September 2005 CAP review. We identified the following organizational strength and reported accomplishment:

- The system improved outpatient clinic access through system redesign.

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

- Initiate pest control measures to eliminate fruit flies on the acute psychiatry unit.
- Seal the hole between the acute psychiatry unit's nutrition kitchen and the housekeeping closet.
- Ensure that acute psychiatry unit bathrooms and showers are cleaned regularly to eliminate and prevent mold.
- Replace standard screws with tamper-proof screws on the acute psychiatry unit.
- Reduce the risk of fire by inspecting and cleaning the acute psychiatry unit's clothes dryer vent on a regular basis and by securing the area around the dryer to prevent objects from falling behind it.
- Eliminate potential exposure to secondhand smoke.
- Comply with Veterans Health Administration (VHA) and system policies governing inter-facility transfers.
- Comply with the system's policy governing intra-facility transfers.

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

- Pharmacy Operations.
- QM Program.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Katherine Owens, Director, Bedford Office of Healthcare Inspections.

Comments

The Acting VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–15, for the full text of the Directors' comments.) We will follow up on the planned actions for Recommendation 7 until they are completed.

(original signed by)

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

Introduction

Profile

Organization. The system provides a broad range of inpatient and outpatient health care services at two divisions located in West Haven and Newington, CT. It also provides outpatient services at six community based outpatient clinics in Danbury, New London, Stamford, Waterbury, Winsted, and Windham, CT. The system is part of VISN 1 and serves a veteran population of more than 333,000 in Connecticut and southern New England.

Programs. The West Haven division is a Clinical Referral Level I Facility. It provides comprehensive health care through primary care, acute care (medicine, surgery, and psychiatry), tertiary care, and long-term care services. Additionally, it provides physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics and extended care services. The Newington division is an ambulatory care center that provides primary and specialty care services.

Affiliations and Research. The system is affiliated with Yale University's School of Medicine and the University of Connecticut's School of Medicine and School of Dentistry. During fiscal year (FY) 2007, the system supported 509 resident and fellow positions and provided training for students in nursing and other health professions.

In FY 2007, the system's research funding from VA and non-VA sources totaled approximately \$54 million. The system had 130 principal investigators and more than 550 projects. Major areas of research included projects in medicine, psychiatry, neurology, dermatology, and radiology.

Resources. In FY 2007, the system's medical care budget totaled over \$277 million. FY 2008 staffing is 2,046 full-time employee equivalents (FTE), including 239 physician and 528 nursing FTE.

Workload. During FY 2007, the system treated more than 54,000 unique patients and provided inpatient treatment to over 4,700 patients. It had 160 operating hospital beds and an average daily census of 134. FY 2007 outpatient workload totaled over 578,000 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 five activities:

- Emergency Department and Urgent Care Centers (ED/UCC).
- Environment of Care (EOC).
- Pharmacy Operations.
- QM Program.
- SHEP.

The review covered system operations for FY 2007 and quarter 1 of FY 2008 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from the prior CAP review of the system (*Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, CT*, Report No. 05-00859-216, September 30, 2005). In that report, we identified improvement opportunities for pressure ulcer prevention and management. During the follow-up review, we found sufficient evidence that managers had

implemented appropriate actions to address the identified deficiencies, and we consider the issue closed.

During this review, we presented fraud and integrity awareness briefings for 314 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 Strength

System Redesign

The system reduced the total number of patients waiting more than 30 days for outpatient care by 70 percent in the first 8 months of FY 2008. This successful redesign process was accomplished through senior leadership's commitment to investing in infrastructure that supported clinic access, filling key vacancies, reducing clinic backlog through Saturday and evening clinics, and standardizing operations across clinic settings.

Results

Review Activities With Recommendations

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards. We inspected patient care areas at both divisions for cleanliness, safety, infection control (IC) processes, and general maintenance.

At the West Haven division, we inspected the following areas: (a) two medical surgical units, (b) two intensive care units, (c) the step-down unit, (d) the post-anesthesia care unit, (e) dialysis, (f) the nursing home care unit, (g) blind rehabilitation, (h) radiology, (i) the acute psychiatry unit, and (j) the ambulatory procedure/endoscopy unit. At the Newington division, we inspected two primary care

areas and the outpatient psychiatry/substance disorder treatment area.

The system maintained a generally clean and safe environment. Additionally, system managers provided documentation of risk assessment and abatement tracking of safety issues identified on the acute psychiatry unit, and environmental risk training for that unit was completed. However, we identified issues that needed management attention at the West Haven division.

Infection Control. The IC program monitored and reported data to clinicians, and the data were used to implement quality of care improvements. However, we found issues on the acute psychiatry unit.

- There were fruit flies in the nutrition kitchen and in a patient room located across from the nutrition kitchen.
- The ice machine in the nutrition kitchen drained into the sink in the housekeeping closet. There was a large hole in the shared wall between the kitchen and the closet with exposed plumbing from the ice machine to the sink. This provided an access point for insects and bacteria to travel from a dirty area (the closet) to a clean area (the kitchen).
- The congregate patient shower had mold on the ceiling, wall, floor tiles, and handrails. Facilities Management Services (FMS) personnel cleaned the shower while we were onsite; however, managers needed to establish a cleaning schedule to prevent and eliminate mold.

Safety. We found the following safety issues on the acute psychiatry unit.

- Air exchange vents located in patient rooms had removable panels attached with standard screws rather than tamper-proof screws. If removed, vent openings can be used as attachment points for suicide attempts. Also, accessible vents can be used to store contraband items. FMS personnel began replacing the standard screws while we were onsite.
- Housekeeping personnel were unable to clean behind the clothes dryer because access to the back of the dryer was blocked. Consequently, excessive lint can build up behind the dryer, creating a fire hazard. Also, it was possible for objects to fall behind the dryer, which

created an additional fire hazard. FMS personnel constructed permanent access to the back of the dryer while we were onsite.

A potential safety risk was brought to our attention. The exhaust fans in the smoking shelter located outside of Building 2 were not operational, and people using the shelter propped open the shelter door to obtain ventilation. Also, the automatic door controls at the entrance to Building 2 in the area of the shelter were not operational, and the door remained open for extended periods. The non-functioning exhaust fans and automatic door controls combined with the propped open shelter door allowed smoke to drift into the building, creating the risk for exposure to secondhand smoke.

Additionally, smokers congregated outside of the shelter in a location below first floor office windows. Some employees who occupied the offices told us that they could smell the smoke. This created a second opportunity for exposure to secondhand smoke.

- Recommendation 1** We recommended that the Acting VISN Director ensure that the System Director takes action to initiate pest control measures to eliminate fruit flies on the acute psychiatry unit.
- Recommendation 2** We recommended that the Acting VISN Director ensure that the System Director takes action to seal the hole between the acute psychiatry unit's nutrition kitchen and the housekeeping closet.
- Recommendation 3** We recommended that the Acting VISN Director ensure that the System Director requires that the acute psychiatry unit's bathrooms and showers are cleaned on a regular basis to eliminate and prevent mold.
- Recommendation 4** We recommended that the Acting VISN Director ensure that the System Director requires that standard screws be replaced with tamper-proof screws on the acute psychiatry unit.
- Recommendation 5** We recommended that the Acting VISN Director ensure that the System Director takes action to reduce the risk of fires by requiring inspection and cleaning of the acute psychiatry unit's clothes dryer vent and by securing the area around the dryer to prevent objects from falling behind the dryer.

Recommendation 6

We recommended that the Acting VISN Director ensure that the System Director takes action to eliminate potential exposure to secondhand smoke.

The Acting VISN and System Directors agreed with the findings and recommendations. They reported that FMS conducted a pest control review of the acute psychiatric unit, sealed the hole between the unit's nutrition kitchen and housekeeping closet, and established a formal cleaning schedule for bathrooms and showers on that unit. They also reported that FMS replaced standard screws with tamper-proof screws on the acute psychiatric unit, established an inspection and cleaning plan for the unit's clothes dryer vent, and secured the area behind the dryer. The EOC Committee will monitor compliance with the corrective actions.

Additionally, the Directors reported that the System Director implemented an aggressive plan to monitor designated smoking areas and that the smoking shelter's door and exhaust system have been repaired. The EOC Committee will monitor compliance with smoking issues. The corrective actions are acceptable, and we consider Recommendations 1–6 closed.

**Emergency
Department and
Urgent Care
Centers**

The purpose of this review was to evaluate selected aspects of care and operations in VHA ED/UCC, such as clinical services, consults, inter- and intra-facility transfers, staffing, and staff competencies. We also determined if the physical environments were clean and safe and if managers maintained equipment appropriately.

We interviewed the directors and nurse managers from the medical emergency room (MER) and the psychiatric emergency room (PER) at the West Haven division and from the UCC at the Newington division. We reviewed policies and other pertinent documents, including equipment maintenance records. Additionally, we interviewed the system's transfer coordinator and reviewed medical records of patients who were transferred to other medical facilities or to inpatient units within the system.

In all three areas, our review showed that clinical services, consults, staffing, and staff competencies (including physician credentialing and privileging) were appropriate. We conducted EOC tours and found that the areas were clean and safe and that equipment was appropriately

maintained. However, we found the following issues that needed improvement.

Inter-Facility Transfers. We reviewed the medical records of six patients who were transferred from the MER, PER, or UCC to other medical facilities for care. Transfer documentation did not comply with VHA regulations¹ or the system's inter-facility transfer policy.² Both VHA and system policy require that VA Form 10-2649A, "Inter-Facility Transfer Form," be completed and sent to the receiving facility at the time of transfer. The medical records showed that the system used a community form that did not comply with VHA regulations or the system's policy.

Intra-Facility Transfers. We reviewed the medical records of 10 patients transferred from the MER, PER, or UCC to inpatient units within the system. The system's policy³ requires SBAR⁴ documentation and the name of the person accepting the transfer. While the records contained some evidence of communication between physicians, SBAR documentation and inclusion of the names of the accepting clinicians was inconsistent.

Recommendation 7 We recommended that the Acting VISN Director ensure that the System Director requires that all inter-facility transfer documentation comply with VHA and system policies.

Recommendation 8 We recommended that the Acting VISN Director ensure that the System Director requires that all intra-facility transfer documentation comply with system policy.

The Acting VISN and System Directors agreed with the findings and recommendations. They reported that Connecticut mandates the use of its own inter-facility transfer form (the W-10). The system will modify the W-10 to include all required elements from VA Form 10-2649A and will revise the system's policy to reflect the changes. This action will be completed by August 15, 2008. They also reported that the intra-facility transfer template was modified to ensure compliance with the system's policy.

¹ VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

² Healthcare System Policy 11-008, *Emergency Medical Services and Inter-facility Transfers*, March 1, 2008.

³ Healthcare System Policy 11-22, *Hand-off Communication*, April 17, 2006.

⁴ The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition.

The implementation plans for Recommendation 7 are acceptable, and we will follow up on the planned actions until they are completed. The corrective action for Recommendation 8 is acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Pharmacy Operations

The purposes of this review were to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances (CS) and the pharmacies' internal physical environments and whether clinical managers had processes to monitor inpatient and outpatient medication use to avoid polypharmacy in vulnerable populations, such as the elderly and mental health patients.

Pharmacy Controls. We reviewed VHA regulations⁵ governing pharmacy and CS security, and we assessed whether the system's policies and processes were consistent with VHA regulations. We reviewed the CS inspection program and inspected inpatient and outpatient pharmacies for security, EOC, and IC issues. In addition, we interviewed CS inspectors and appropriate Pharmacy Service and Police and Security Service managers.

The system's CS inspection program was well organized and properly managed, and the system met the requirements outlined in VHA policy. Data showed that the number of discrepancies found during the monthly CS inspections decreased significantly from 195 in quarter 1 of FY 2005 to 10 in quarter 2 of FY 2008. The pharmacies' environments were clean and safe, and managers reported suspected CS diversions to the OIG.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of:

⁵ VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

(a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.⁶ Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.⁷

We interviewed pharmacy clinical managers to determine the system's efforts to monitor and avoid inappropriate polypharmacy. Clinical pharmacists identified patients who were prescribed multiple medications, reviewed the patients' medication regimens to avoid complications related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate. We made no recommendations.

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, and Coordinator of Performance Improvement (PI). We evaluated policies, PI data, and other relevant documents.

The system's QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. In addition, clinical managers developed and implemented a provider performance evaluation plan. We made no recommendations.

Survey of Healthcare Experiences of Patients

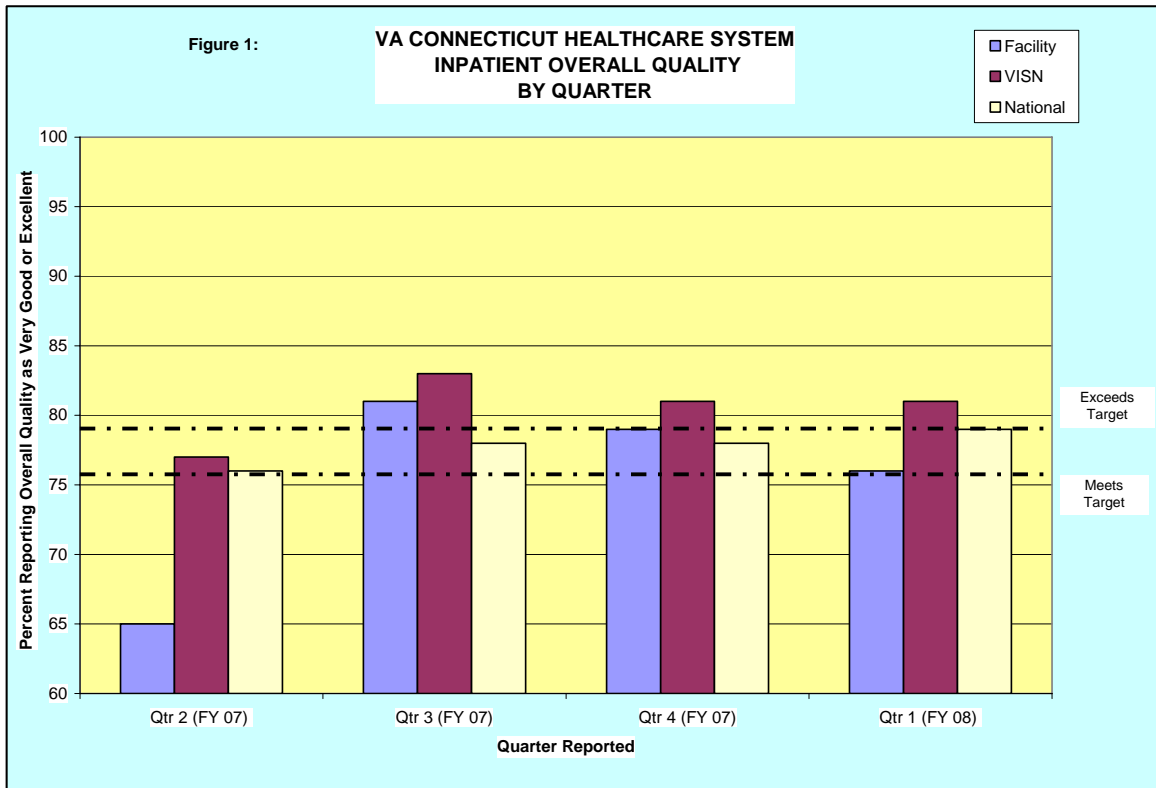
The purpose of this review was to assess the extent that VHA medical facilities used quarterly or semi-annual SHEP results to improve patient care and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall

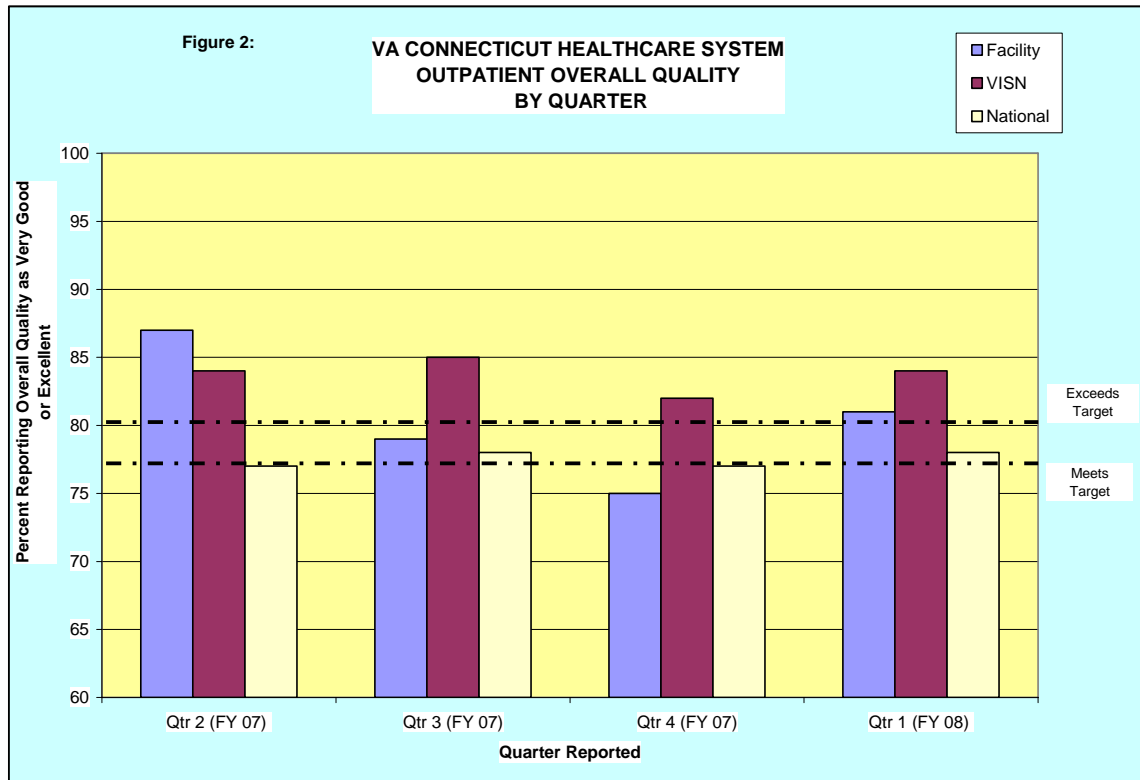
⁶ Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

⁷ Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21-23, January 2006.

satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percent for outpatients.

We reviewed survey results for quarters 2–4 of FY 2007 and quarter 1 of FY 2008. The system’s inpatient and outpatient scores met or exceeded VHA’s target goals in 3 of 4 quarters. The results are displayed in the following graphs.





System managers analyzed their survey results, developed improvement strategies, and monitored the results of the action plans. Survey results and improvement strategies were disseminated throughout the organization. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 10, 2008

From: Acting Director, VA New England Healthcare System (10N1)

Subject: **Combined Assessment Program Review of the VA
Connecticut Healthcare System, West Haven,
Connecticut**

To: Director, Bedford Office of Healthcare Inspections (54BN)
Director, Management Review Service (10B5)

We concur with responses from Connecticut HCS to the recommendations made as a result of the Combined Assessment Program Review.

(original signed by:)

TAMMY FOLLENSBEE,
Acting Network Director

System Director Comments

Department of
Veterans Affairs

Memorandum

Date: July 10, 2008

From: Director, VA Connecticut Healthcare System (689/00)

Subject: **Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut**

To: Director Bedford Office of Healthcare Inspections (54BN)
Director, Management Review Service (10B5)

We wish to thank the Office of the Inspector General for the opportunity to respond to the recent Combined Assessment Program Review at the Connecticut VA Healthcare System. We appreciated the constructive approach taken during the survey.

The following are the responses to the recommendations.

Recommendation 1. We recommended that the Acting VISN Director ensure that the System Director takes action to initiate pest control measures to eliminate fruit flies on the acute psychiatry unit.

Concur

The System Director has ensured that a pest control review has been conducted in the area and has initiated a team to change dispensing practices to eliminate the use of fruit drinks in dispensing medications on the unit, which will attack the issue that is drawing the fruit flies on the unit. This recommendation was corrected as of July 1, 2008. This will be tracked through the Environment of Care Committee. As such, we recommend this issue be closed.

Recommendation 2. We recommended that the Acting VISN Director ensure that the System Director takes action to seal the hole between the acute psychiatry unit's nutrition kitchen and the housekeeping closet.

Concur

The System Director took action to ensure this issue was corrected while the OIG CAP Team was onsite. The facilities management department sealed the hole between the psychiatry unit's nutrition kitchen and the housekeeping closet. As such, we recommend this issue be closed.

Recommendation 3. We recommended that the Acting VISN Director ensure that the System Director requires that the acute psychiatry unit's bathrooms and showers are cleaned on a regular basis to eliminate and prevent mold.

Concur

The System Director took action to ensure the showers were cleaned while the OIG CAP Team was onsite, and a formal cleaning schedule for the bathrooms and showers has been implemented. Weekly inspections of the area, including bathroom and showers, will be conducted and tracked through the Environment of Care Committee. As such, we recommend this issue be closed.

Recommendation 4. We recommended that the Acting VISN Director ensure that the System Director requires that standard screws be replaced with tamper-proof screws on the acute psychiatry unit.

Concur

The System Director initiated action to have the standard screws replaced with tamper-proof screws. This effort has begun and will be completed by July 15, 2008. This will be tracked through the Environment of Care Committee. This action is currently open until completed.

Recommendation 5. We recommended that the Acting VISN Director ensure that the System Director takes action to reduce the risk of fire by requiring inspection and cleaning of the acute psychiatry unit's clothes dryer vent and by securing the area around the dryer to prevent objects from falling behind the dryer.

Concur

The System Director ensured that corrective action was taken on this issue while the OIG CAP Team was onsite. The unit staff will perform inspections and needed cleaning of the acute psychiatry unit's clothes dryer vent. This will also be an inspection item during Environment of Care Rounds. This will be monitored through the Environment of Care Committee. The area behind the dryer was secured while the OIG CAP Team was onsite to prevent objects from falling behind the dryer. As such, we recommend this issue be closed.

Recommendation 6. We recommended that the Acting VISN Director ensure that the System Director eliminates potential exposure to secondhand smoke.

Concur

The System Director has implemented an aggressive plan for ongoing monitoring of designated smoking areas to eliminate potential exposure to secondhand smoke throughout the facility. For the smoking shelter in question, the exhaust system and the door to the smoking area has been fixed to assure that it closes properly. Smoking issues such as this are tracked monthly through the Environment of Care Committee. Based on these actions, we recommend this issue be closed.

Recommendation 7. We recommended that the Acting VISN Director ensure that the System Director requires that all inter-facility transfer documentation comply with VHA and system policies.

Concur

The W-10 form, which is a State of Connecticut mandated inter-facility transfer form, has been modified in CPRS to include all required elements from the VHA 10-2649A form and to address the issue cited. The W-10 transfer note will be renamed "W-10/Interfacility Transfer (10-2649A)" note. The Health System policy has been revised to reflect the changes in the process. The Director has chartered an interdisciplinary team to monitor the correct usage of this form and documentation compliance, with reports going through the Quality Management Department to the Governing Body. This action is currently open, and will be completed no later than August 15, 2008.

Recommendation 8. We recommended that the Acting VISN Director ensure that the System Director requires that all intra-facility transfer documentation comply with system policy.

Concur

The template for documenting transfers has been modified in CPRS to address the issue cited and includes all required elements. The System Director has chartered an interdisciplinary team to monitor usage of the template and documentation to ensure compliance with the system policy. The results of this monitoring will be submitted through the Quality Management Department to the Governing Body. Based on these actions, we recommend this issue be closed.

Again, we appreciate the opportunity to respond to the recommendations and the constructive approach taken by the team during the survey.

OIG Contact and Staff Acknowledgments

| | |
|---------------------|--|
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