Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02081-09

Combined Assessment Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina

October 27, 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
COC	coordination of care
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	Fayetteville VA Medical Center
FY	fiscal year
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, NC

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 July 11, 2011.

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

- Coordination of Care
- Management of Workplace Violence

The facility's reported accomplishments were its strong resource sharing partnership with Womack Army Medical Center and gynecological continuity of care for the female veteran population.

Recommendations: We made recommendations in the following five activities:

Physician Credentialing and Privileging: Correct privilege form irregularities, and ensure privilege forms are completed appropriately. Ensure that Focused and Ongoing Professional Practice Evaluation forms contain results of the data analyzed. Require privileges to comply with Veterans Health Administration requirements.

Quality Management: Ensure that all services provide the required medical record reviews and that the reviews include all required components. Require medical record review processes to include monitoring the copy and paste functions.

Environment of Care: Complete N95 respirator fit testing and bloodborne pathogens training annually, and monitor compliance. Ensure that the security of crash cart locks is checked and documented in accordance with local policy and that compliance is monitored.

Registered Nurse Competencies: Ensure that competency documents contain all required signatures and dates.

Enteral Nutrition Safety: Ensure that all nasogastric tube placements are confirmed with x-rays prior to initiating feedings.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- COC
- EN Safety
- EOC
- Management of Workplace Violence
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through July 11, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina,* Report No. 08-01447-68,

February 17, 2009). (See Appendix B for further details.) The facility had a repeat finding in the area of QM.

During this review, we also presented crime awareness briefings for 137 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

Sharing Partnership

The facility and Womack Army Medical Center enjoy a strong resource sharing partnership with goals to improve access to care and cost savings. Veterans from the facility have access to Womack's vascular surgery, urology, orthopedics, and gynecology services. In addition, staff from Womack train at the facility for sleep study certification and reciprocated nurse training, and staff from the facility train at Womack for out-of-operating room airway management. During FY 2010, the facility saved $98,971 through this partnership.

Gynecological Continuity of Care

The facility increased the continuity of care for the female veteran population by purchasing new equipment, which allows them to meet routine and complex gynecological needs. The facility also entered into a sharing agreement with Womack Army Medical Center that allows the facility's staff gynecologist to perform complex gynecological surgeries at Womack. These surgeries were previously contracted out to the local civilian hospital.

Results

Review Activities With Recommendations

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 12 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 areas that needed improvement.

Privilege Forms. VHA requires privilege forms to conform to certain formats.[1] Five of the 12 privilege request forms we reviewed did not contain all the required elements. For example, some of the forms had blank signature blocks and missing initials.

Focused and Ongoing Professional Practice Evaluation. VHA requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing periodic basis.[2] Five of the 12 physician profiles reviewed had Focused and Ongoing Professional Practice Evaluation forms that lacked documentation of the data analyzed.

Privileges. VHA requires that privileges granted to a physician be specific to the facility, service, setting, and provider.[3] We found that 7 of the 12 provider profiles reviewed did not comply with VHA requirements. For example, one provider lacked privileges for the type of care provided, and another provider had privileges that were outside the scope of practice for that clinic.

Recommendations

1. We recommended that privilege form irregularities be corrected and that processes be strengthened to ensure that privilege forms are completed appropriately.

2. We recommended that processes be strengthened to ensure that Focused and Ongoing Professional Practice Evaluation forms contain results of the data analyzed.

3. We recommended that privileges comply with VHA requirements.

QM

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

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

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1100.19.
[3] VHA Handbook 1100.19.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review and to monitor the copy and paste functions.[4] We found that multiple services did not provide the required medical record reviews and that medical record reviews did not include all of the required components. For example, we found that from July 2010 until January 2011, the facility did not review any service-level reports. This was a repeat finding from the previous CAP review. In addition, the facility did not monitor the copy and paste functions in the electronic medical record.

Recommendations

4. We recommended that processes be strengthened to ensure that all services provide the required medical record reviews and that the reviews include all required components.

5. We recommended that medical record review processes be strengthened to ensure that the copy and paste functions are monitored.

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 a community living center, same day surgery, the post-anesthesia care unit, behavioral health, and the medical-surgical and intensive care units. We also inspected the dental clinic and a combined primary care clinic/ED. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires that designated employees be fit tested annually if the facility uses N95 respirators. We reviewed 25 employee training records and determined that 24 employees did not have the required annual fit testing.

The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule. We reviewed 14 employee training records and found that 3 employees did not have this training documented.

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Medication Security. Local policy requires that crash cart lock security be checked and documented once during each tour of duty in areas where 24-hour service is provided. Emergency medications are stored in locked crash carts located in strategic locations throughout the facility. We found crash carts in three different areas (the ED, behavioral health, and the intensive care unit) that did not have the required documentation for several tours of duty during the past month.

Recommendations

6. We recommended that N95 respirator fit testing and bloodborne pathogens training be completed annually and that compliance be monitored.

7. We recommended that the security of crash cart locks be checked and documented in accordance with local policy and that compliance be monitored.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse leaders, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. Local policy requires that both the employee and supervisor sign the competency document. In addition, the supervisor and the employee must sign and date each item in the document. Ten out of the 12 RN competency folders reviewed had missing signatures and/or missing dates.

Recommendation

8. We recommended that processes be strengthened to ensure that competency documents contain all required signatures and dates.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

X-Ray Confirmation. VHA requires that health care staff confirm placement of a nasogastric tube with an x-ray prior to using the tube for feeding.[5] We reviewed the medical records of 15 patients. Of the 10 applicable patients, we found that 3 intensive care unit patients with nasogastric tubes did not have the required x-ray confirmation prior to initiating feedings via the tube.

Recommendation

9. We recommended that processes be strengthened to ensure that all nasogastric tube placements are confirmed with x-rays prior to initiating feedings.

Review Activities Without Recommendations

COC

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

We reviewed patients' medical records and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive management of workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

Comments

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

[5] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

Facility Profile[6]		
Type of Organization	Medical center – non tertiary care	
Complexity Level	3	
VISN	6	
Community Based Outpatient Clinics	Hamlet, NC Jacksonville, NC Robeson County (Pembroke), NC Wilmington, NC	
Veteran Population in Catchment Area	187,338	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	56	
• **Community Living Center/Nursing Home Care Unit**	49	
• **Other**	N/A	
Medical School Affiliation(s)	Duke-Southern Regional Area Health Education Center (SR-AHEC) East Carolina University Womack Army Medical Center	
• **Number of Residents**	8	
	Current FY (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$98.3	$171.5
• **Medical Care Expenditures**	$88.8	$171.5
Total Medical Care Full-Time Employee Equivalents	889	810
Workload:		
• **Number of Station Level Unique Patients**	40,245	47,463
• **Inpatient Days of Care:**		
o **Acute Care**	6,912	13,500
o **Community Living Center/Nursing Home Care Unit**	8,315	18,348
Hospital Discharges	1,218	2,712
Total Average Daily Census (including all bed types)	84	87
Cumulative Occupancy Rate (in percent)	64.9	67.6
Outpatient Visits	198,640	389,072

[6] 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**
EOC			
1. Require Facility Management Service to conduct a facility-wide cleaning project and to increase monitoring of routine cleaning.	A facility-wide cleaning project was completed December 19, 2008. A cleaning schedule was developed for routine and deep cleaning. Cleaning is monitored through EOC rounds and reported to the EOC Committee.	Y	N
2. Require Engineering Service to monitor the completion of work orders for timeliness.	Facility policy was updated with a new classification for work orders. Work order completion is tracked for timeliness by the EOC Committee.	Y	N
3. Document regular testing of the WanderGuard® system.	The Associate of Patient Care Services for Long Term Care ensures that testing of the WanderGuard® system occurs and is documented daily. Compliance is reported to the Nurse Executive Committee.	Y	N
4. Store clean linen appropriately.	Nurse managers conduct random checks and report results to the Nurse Executive Committee.	Y	N
QM			
5. Ensure committee meeting minutes comply with facility policy.	A new policy and meeting minutes format were implemented, and the new format is in use by most committees.	Y	N
6. Ensure the peer review process complies with facility policy.	Quarterly peer review activities are reported to the Medical Executive Board.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
7. Ensure the Utilization Management Committee meets as required.	The Utilization Management Committee meets at least six times a year.	Y	N
8. Monitor and evaluate moderate sedation outcomes.	Moderate sedation outcomes are monitored quarterly by the Operative and Other Invasive Procedure Committee.	Y	N
9. Monitor resuscitation outcomes.	Resuscitation outcomes are reported monthly to the Critical Care Committee.	Y	N
10. Conduct medical record reviews in accordance with VHA policy.	Medical record reviews have not been consistently completed by the Medical Records Committee.	N	Y (see page 4)
COC			
11. Complete discharge documentation as required by VHA policy	Discharge documentation training was completed, and the discharge instruction template was modified to automatically incorporate outpatient medications. Clinical services monitor compliance and report findings to the Medical Records Committee quarterly.	Y	N
Emergency/Urgent Care Operations			
12. Maintain privacy in the ED.	Patient privacy screens are in use in the temporary ED location. Nursing staff in the ED received patient privacy education.	Y	N

VHA Satisfaction Surveys

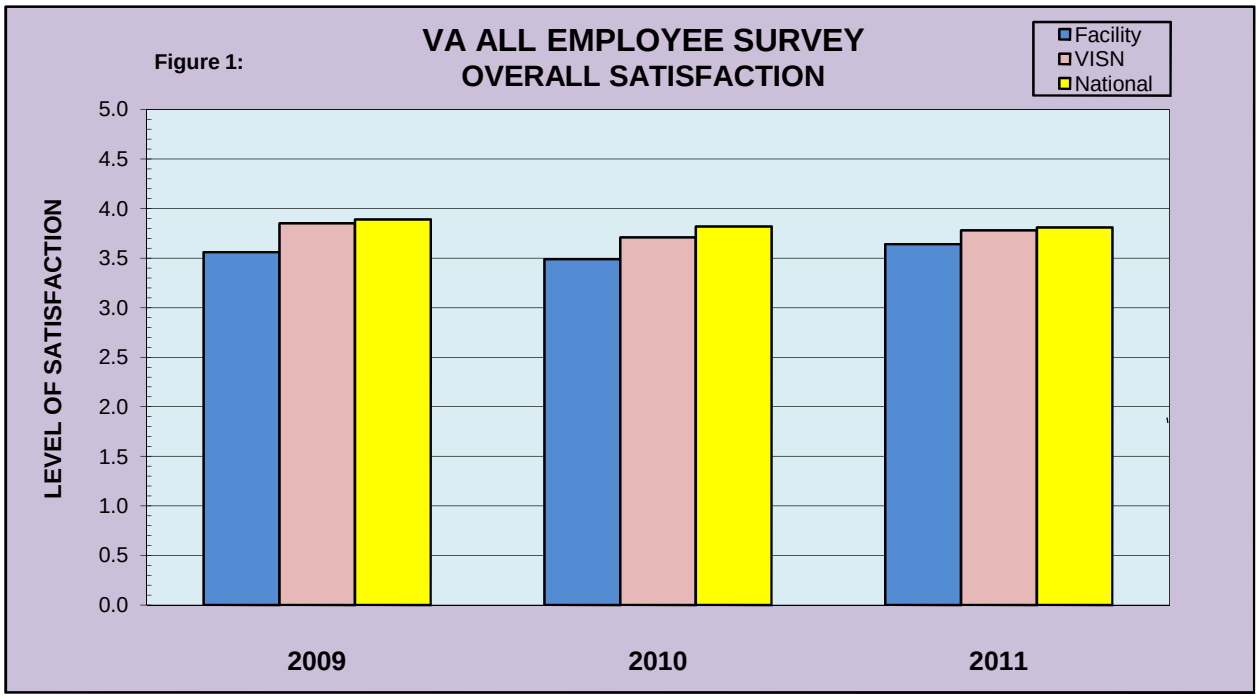
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	46.2	44.3	40.2	49.7	37.9	37.7
VISN	62.0	52.2	46.5	62.8	50.1	49.5
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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[7] 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	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	*	9.22	13.10	*	21.39	15.64
VHA	13.31	9.73	15.08	20.57	21.71	15.85

* Not enough cases

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 7, 2011

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. The attached subject report is forwarded for your review and further action. I have reviewed the responses and concur with the facility's recommendations.

2. Please contact Elizabeth Goolsby, Director, Fayetteville VA Medical Center, at 901-822-7059, if you have any further questions.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2011

From: Director, Fayetteville VA Medical Center (565/00)

Subject: **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

Fayetteville VA Medical Center concurs with findings. We have provided the specific corrective actions we have taken for each recommendation and clarification of action items (1) and (9) as requested.

(original signed by:)
ELIZABETH GOOLSBY

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 privilege form irregularities be corrected and that processes be strengthened to ensure that privilege forms are completed appropriately.

Concur

Target completion date: November 30, 2011

Response: The Fayetteville VAMC (FVAMC) Director concurs with the findings and submits the following action plan.

A review of 100% of the Credentialing and Privileging files has been scheduled to ensure inconsistencies with missing signatures and initials are corrected. This review will be completed by Nov 30th, 2011.

To conduct this review, a standardized review form **"Initial Application Checklist**" will be utilized. This form has been revised to incorporate checking for missing signatures and initials.

At the conclusion of the initial review, and to ensure appropriate actions are sustained and effective, each credentialing staff member will conduct a random review of five C & P files per month utilizing the **Initial Application Checklist**. The results will be reviewed and addressed monthly by the Chief, Performance Improvement and shared with leadership as appropriate at Executive Leadership Board meetings.

Recurrent education and training has been scheduled for the credentialing and privileging staff to ensure appropriate completion of the C & P forms and documents. This training will be conducted in November 2011.

Recommendation 2. We recommended that processes be strengthened to ensure that Focused and Ongoing Professional Practice Evaluation forms contain results of the data analyzed.

Concur

Target completion date: July 29, 2011

Response: The FVAMC Director concurred with the findings. A standardized form was implemented hospital wide in July 2011 to capture trending and analysis documentation

over time and is then maintained in each physician's profile. Education and training was provided to ensure appropriate completion of forms.

Recommendation 3. We recommended that privileges comply with VHA requirements.

Concur

Target completion date: November 2011

Response: The FVAMC Director concurred with the findings. An inventory of all privileges was completed to ensure compliance with all VHA requirements. Privilege forms are under review with site specific privileges being addressed to comply with the VHA directive.

Recommendation 4. We recommended that processes be strengthened to ensure that all services provide the required medical record reviews and that the reviews include all required components.

Concur

Target completion date: October 31, 2011

Response: The FVAMC Director concurred with the findings. A review of all required medical record reviews and the required components is scheduled to be completed during the September 2011 Medical Records Committee meeting. Expectations and requirements are also being communicated to the appropriate Service Chiefs. Ongoing compliance is monitored in the Medical Executive Board.

Recommendation 5. We recommended that medical record review processes be strengthened to ensure that the copy and paste functions are monitored.

Concur

Target completion date: October 31, 2011

Response: The FVAMC Director concurred with the findings. The requirement for compliance with the copy and paste functions has been defined. A memorandum is under development to address copy and paste requirement and guidance. Following its completion appropriate education and training will occur. Monitoring of this important element of the medical records will be ongoing, reported and captured in the Medical Records Committee minutes. Data will be trended, analyzed and presented also to the Medical Executive Board.

Recommendation 6. We recommended that N95 respirator fit testing and bloodborne pathogens training be completed annually and that compliance be monitored.

Concur

Target completion date: November 30, 2011

Response: The FVAMC Director concurred with the findings. An assessment was completed in July 2011 to determine staff required to complete fit testing and blood borne pathogens training. A three day session was held in August to conduct fit test training. Additional sessions are scheduled for completion of the remaining staff as well as a routine schedule implemented to ensure achievement of annual requirement. The staff fit test compliance and blood borne pathogen training has been added as an agenda item in the Infection Prevention Committee to ensure sustained compliance.

Recommendation 7. We recommended that the security of crash cart locks be checked and documented in accordance with local policy and that compliance be monitored.

Concur

Target completion date: July 29, 2011

Response: The FVAMC Director concurred with the findings. Process revised in July 2011 to ensure services check crash carts daily to ensure security of crash carts. Education and training was provided to the services to ensure appropriate compliance. Reports of monitoring and compliance will be captured in the Pharmacy and Therapeutics Committee minutes and non-compliance related issues will be addressed and reported to the Medical Executive Board.

Recommendation 8. We recommended that processes be strengthened to ensure that competency documents contain all required signatures and dates.

Concur

Target completion date: August 31, 2011

Response: The FVAMC Director concurred with the findings. All competency folders were reviewed and corrected to ensure compliance with the local policy. In addition a schedule was established to review competency folders and ensure that all RN competencies contain all required signatures and dates. Compliance of this process is monitored in the Nurse Executive Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that all nasogastric tube placements are confirmed with x-rays prior to initiating feedings.

Concur

Target completion date: July 29, 2011

Response: The FVAMC Director concurred with the findings. The enteral medical center policy was developed in July 2011 and includes the requirement for x-ray confirmation after nasogastric tube placements prior to initiating feedings. Following its completion appropriate education and training occurred.

An order set, using criteria related to x-ray confirmation requirements has been created and is currently in use. A tracking tool was developed using this same criteria. This tool is being used to confirm compliance with each nasogastric tube placement. Any deviations from practice are addressed daily to the respective discipline. The results are reported daily on the Nursing Report and are being discussed at the Nurse Executive Committee. This will be reported monthly for six consecutive months (stabilization of process) and then quarterly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Contributors	Donna Giroux, RN, Project Leader Bruce Barnes, Team Leader Myra Conway, RN Katharine Foster, RN Kathy Gudgell, RN, JD Julie Watrous, RN Natalie Sadow-Colón, MBA, Program Support Assistant Robert LaChapelle, Special Agent, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid-Atlantic Health Care Network (10N6)
Director, Fayetteville VA Medical Center (565/00)

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: Richard Burr, Kay R. Hagan
U.S. House of Representatives: G.K. Butterfield, Renee Ellmers, Walter B. Jones, Larry Kissell, Mike McIntyre

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