Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02603-05

Combined Assessment Program Review of the Oscar G. Johnson VA Medical Center Iron Mountain, Michigan

October 7, 2009

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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Table of Contents

Executive Summary

Introduction

During the week of July 20, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Oscar G. Johnson VA Medical Center (the medical center), Iron Mountain, MI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 131 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

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

- Green Environmental Management System (GEMS) program received recognition.
- Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) transition efforts noteworthy.

We made recommendations in all five of the activities reviewed; one environment of care (EOC) recommendation was a repeat recommendation from our prior CAP review. For these activities, the medical center needed to:

- Establish a process for tracking and trending results of medical records reviews.
- Regularly inspect patient care equipment and repair or remove from service items with compromised surfaces.
- Secure sensitive patient information.
- Secure sharp items.
- Complete intra-facility transfer documentation in accordance with medical center policy.
- Complete discharge documentation in accordance with Veterans Health Administration (VHA) policy.
- Assess and document pain medication effectiveness within the timeframe specified by medical center policy.
- Ensure that the Ongoing Professional Practice Evaluation (OPPE) plan, OPPE data, and the physician privileging

process are managed in accordance with VHA requirements.

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago and Kansas City Offices of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–16 for full text of the Directors' comments.) 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

Introduction

Profile

Organization. The medical center is a primary and secondary level facility located in Iron Mountain, MI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics in Hancock, Ironwood, Marquette, Menominee, and Kincheloe, MI, and in Rhinelander, WI. The medical center is part of VISN 12 and serves a veteran population of about 56,000 throughout 15 counties in Michigan and 8 counties in northeastern Wisconsin.

Programs. The medical center provides comprehensive health care through primary care, acute care (medicine and surgery), outpatient mental health, and extended care services. It also provides telemedicine, telepsychiatry, teleradiology, and telepathology services. The medical center has 17 hospital beds and 40 community living center (CLC) beds.

Affiliations and Research. The medical center has no medical school affiliations but is affiliated with Bay de Noc Community College for associate degree registered nurse and licensed practical nurse programs and a phlebotomy certification program. The medical center is also affiliated with Northern Michigan University for bachelor's and master's level nursing students and with Northeast Wisconsin Technical College for a phlebotomy certification program.

Resources. In FY 2008, medical care expenditures totaled $89.1 million. The FY 2009 medical care budget was $97.3 million. FY 2009 staffing was 549 full-time employee equivalents (FTE), including 37 physician and 102 nursing FTE.

Workload. In FY 2008, the medical center treated 12,557 unique patients and provided 4,577 inpatient days in the hospital and 13,343 inpatient days in the CLC. The inpatient care workload totaled 1,209 discharges, and the average daily census, including CLC patients, was 49. Outpatient workload totaled 135,306 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:

- Coordination of Care.
- EOC.
- Medication Management.
- Physician Credentialing and Privileging (C&P).
- QM Program.

The review covered medical center operations for FY 2008 and FY 2009 through July 17, 2009, 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 medical center (*Combined Assessment Program Review of the Iron Mountain VA Medical Center, Iron Mountain, Michigan,* Report No. 06-00510-192, August 17, 2006). We identified one repeat finding regarding security of sharp items from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 131 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.

Organizational Strengths

Green Environmental Management System Program Received Recognition

The medical center's GEMS program continues to be a leader among VA facilities in the implementation of Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management," January 24, 2007. In FY 2008, the medical center was recognized for its effort by the national organization Practice Greenhealth, winning environmental excellence awards in the categories of Partner for Change and Making Medicine Mercury-Free. In addition, the medical center received the Bronze Award from the Environmental Protection Agency for outstanding work in the field of electronics recycling. The medical center has successfully demonstrated how health care facilities can develop and implement pollution prevention programs to improve the health of patients, staff, and the community.

Operation Enduring Freedom/Operation Iraqi Freedom Transition Efforts Noteworthy

The medical center's OEF/OIF team coordinates efforts to reach military service members returning from Iraq and Afghanistan. The medical center currently serves 1,223 unique OEF/OIF veterans. It ranks first in the VISN and eleventh in the nation in completion of post-deployment screens with a completion rate of 99.8 percent. Outreach efforts include visiting all armories in the Iron Mountain catchment area; attending job fairs, health fairs, and Yellow Ribbon events; facilitating Post-Deployment Health Reassessments; and sponsoring Welcome Home events. The medical center also collaborates with the Escanaba Vet Center to provide information regarding VA health care and benefits to National Guard and Reserve members in the area.

Results

Review Activities With Recommendations

Quality Management Program

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

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 13 of the 14 program activities reviewed. We identified one area that needed improvement.

Medical Records Reviews. VHA policy[1] requires that health records are reviewed at the point of care by people who document in the record. A representative sample of inpatient and outpatient records from each service and program must be reviewed using organizationally defined indicators to ensure adequate, timely, complete, and properly authenticated documentation that is compliant with Joint Commission (JC) standards and VHA policy. We found that there was no formal process for tracking and trending results of reviews of significant entries in medical records, such as physician orders, restraint orders, and problem lists.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director establishes a process for tracking and trending results of medical records reviews.

The VISN and Medical Center Directors agreed with the finding and recommendation. A document to track medical record review elements will be implemented, and PI will oversee the monitoring of medical records at the point of care. Results will be reported to the Medical Records Committee and to the Continuous Survey Readiness Committee, which contains a senior leadership component.

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

The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

We inspected the CLC, the intensive care unit (ICU), the inpatient medical/surgical unit, two primary care clinics, the emergency department (ED), the outpatient surgery clinic and procedure area, and the mental health clinic. We evaluated the infection control (IC) program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

The medical center maintained a generally clean and safe environment. Managers and employees were responsive to environmental concerns identified during our inspection. We identified the following conditions that needed improvement.

IC. Staff need to regularly inspect patient care equipment, and items with compromised surfaces need to be repaired or removed from service Compromised surfaces were noted on a wheelchair in the ED, a wheelchair and geri-chair in the inpatient medical/surgical unit, a chair in the outpatient surgery clinic's public restroom, and two wheelchairs in the outpatient surgery procedure area.

Patient Privacy. The Health Insurance Portability and Accountability Act requires that sensitive patient information be secured. We found unsecured information with patients' names, social security numbers, dates of birth, and health information at the CLC nurses' station, on a CLC bulletin board, and on a table in the chemotherapy infusion room.

Environmental Safety. During our prior CAP review, we identified unsecured sharp items, such as needles, scissors, and knives, as a finding. This deficiency had not been corrected. In the ED, there were unsecured scissors on the counter and sharp items in an unlocked soiled utility room and in an unlocked equipment cart. In a primary care clinic,

there was an unsecured diabetic kit that contained needles. Additionally, there was a knife left in the sink in the outpatient surgery clinic's unsecured break room.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that patient care equipment be regularly inspected and that items with compromised surfaces be repaired or removed from service.

The VISN and Medical Center Directors agreed with the findings and recommendation. The items noted during the OIG inspection were immediately removed from service. On September 15, 2009, patient care equipment was added to EOC Committee rounds. Any findings will be noted on the EOC rounds tracking spreadsheet and will be reported quarterly to the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that sensitive patient information be secured.

The VISN and Medical Center Directors agreed with the findings and recommendation. Staff education on maintaining protected patient information was provided on September 16, 2009. The Privacy Officer makes weekly rounds and maintains a spreadsheet of areas reviewed, findings, and corrective action plans. EOC rounds also include surveillance of sensitive patient information. Any findings will be presented to the Continuous Survey Readiness Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that sharp items be secured.

The VISN and Medical Center Directors agreed with the findings and recommendation. Managers reinforced the need to assure that all sharps are secured, and staff were educated regarding this safety issue. Security of sharp items is monitored during EOC rounds, and any findings will be reported to the EOC Committee and to the Continuous Survey Readiness Committee. Managers will develop and implement corrective action plans to address any

deficiencies. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes. We identified the following areas that needed improvement.

Intra-Facility Transfers. Medical center policy requires that transferring staff complete appropriate documentation for each transfer. We reviewed the medical records of 10 patients who were transferred within the medical center and found that 6 (60 percent) of the records did not have the documentation required by medical center policy.

Discharges. VHA policy[2] requires that specific information, such as diet and activity level, be included in both the discharge summary and patient discharge instructions. We reviewed the medical records of 10 patients who were discharged and found that 4 (40 percent) of the records did not have the documentation required by VHA policy.

Recommendation 5

We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete intra-facility transfer documentation in accordance with medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. The nursing transfer template has been updated and now includes all elements required by medical center policy. The Chief of Staff re-educated providers on the need to include hand-off report information in their documentation. Ten records per month will be reviewed for compliance, and results will be reported to the Medical Records Committee and to the Continuous Survey Readiness Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[2] VHA Handbook 1907.01.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. All providers were re-educated on VHA requirements for discharge instructions, and a discharge template has been provided. Ten charts per month will be reviewed for compliance, and results will be reported to the Medical Records Committee and to the Continuous Survey Readiness Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the medical center had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medical/surgical unit, the ICU, and the CLC.

We found that the medical center had a designated Bar Code Medication Administration (BCMA) Program coordinator who had appropriately identified and addressed problems. In addition, pharmacy staff had completed monthly medication reviews for CLC patients. We identified one area that needed improvement.

Pain Medication Effectiveness Documentation. We reviewed the medical records of 10 patients who received a total of 58 doses of pain medication. Medical center policy requires that nurses assess and document the effectiveness of pain medication within 120 minutes after administration. We found that only 27 (47 percent) of the 58 doses had effectiveness documented within the medical center's established timeframe.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently assess and document pain medication effectiveness within the timeframe specified by medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. The BCMA coordinator will provide a weekly report to nurse managers regarding compliance with documentation requirements. Action plans will be developed and tracked to completion for areas not meeting the 90 percent compliance rate. A weekly summary

will be provided to the Associate Director for Nursing and Patient Care Service. Results will be reported to the Continuous Survey Readiness Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[3] We also reviewed meeting minutes during which the physicians' privileges were discussed and recommendations were made.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluations were appropriately implemented for the two physicians hired within the past 12 months. However, we identified one area that needed improvement.

OPPE. VHA regulations require a thorough written plan with specific competency criteria for OPPE for all privileged physicians. The medical center's written plan did not include service-specific competency criteria. OPPE data for the eight physicians who had been reprivileged during the past 12 months were not sufficient to meet current requirements. Also, Clinical Executive Board meeting minutes did not reflect detailed discussion of any physician's performance data prior to reprivileging.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that the OPPE plan, OPPE data, and the privileging process are managed in accordance with VHA requirements.

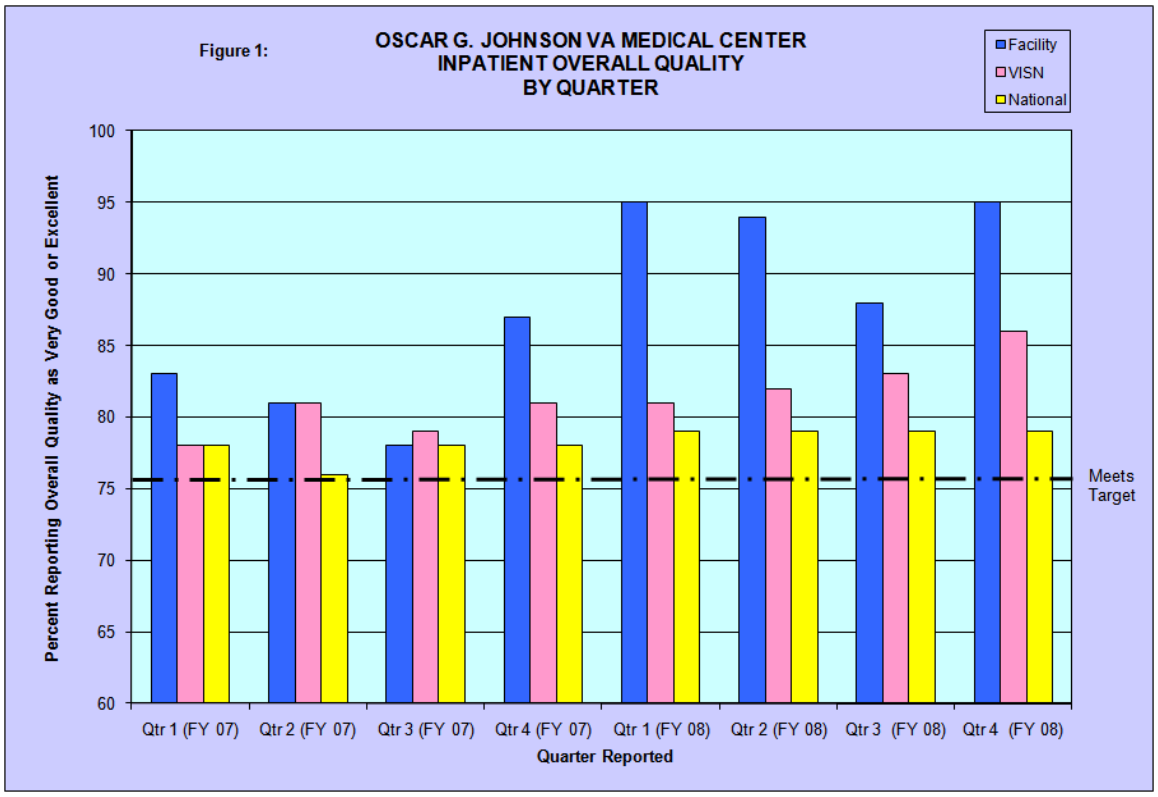
The VISN and Medical Center Directors agreed with the findings and recommendation. A draft policy has been written and shared with service chiefs. The final policy will be published after comments are reviewed. OPPE sheets have been in use and have been updated to include service-specific competency criteria. Clinical Executive Board minutes will now include discussion of performance

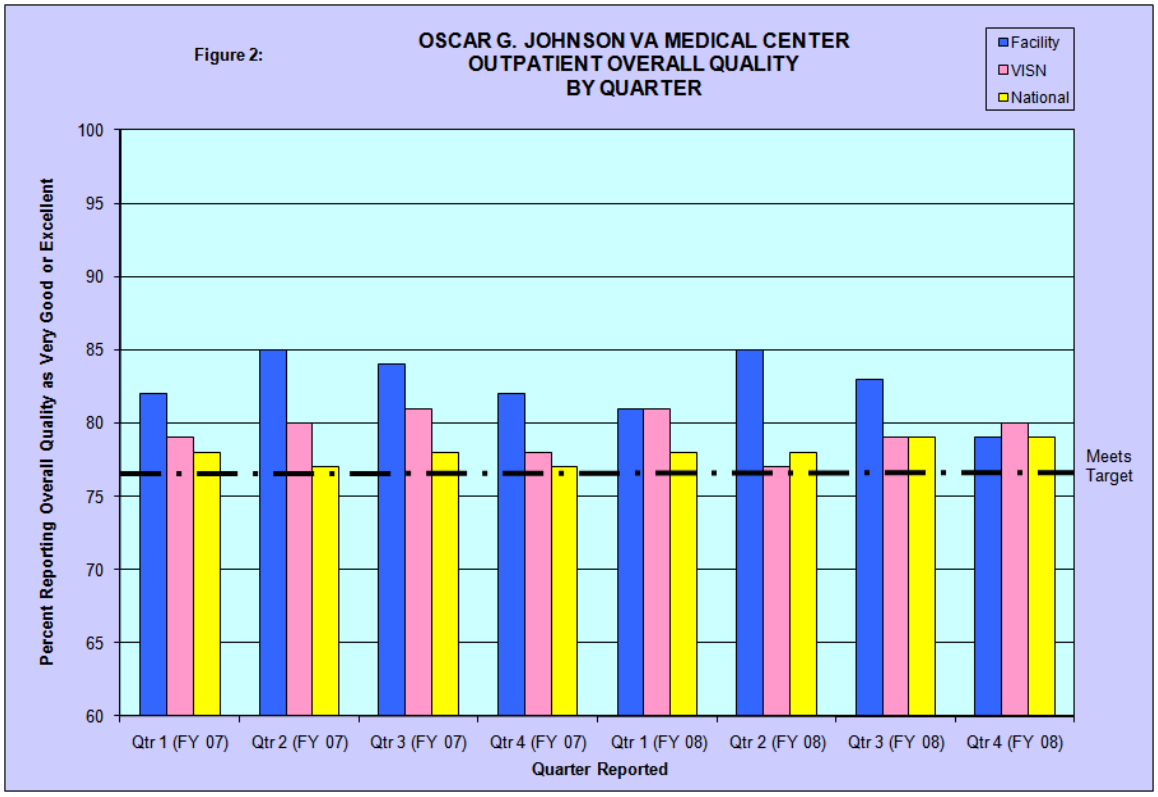
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

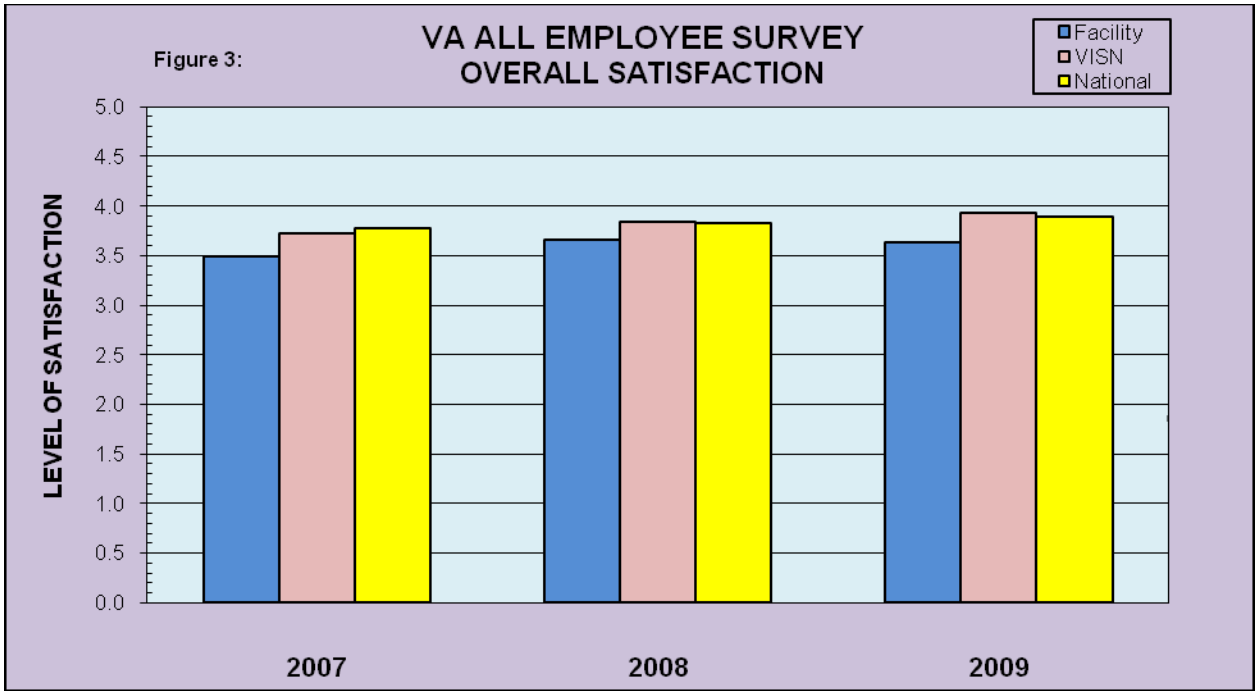
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figures 1 and 2 below and on the next page show the medical center, VISN, and national overall inpatient and outpatient satisfaction scores for FYs 2007 and 2008. Target scores are noted on the graphs.





Employees are surveyed annually. Figure 3 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 15, 2009

From: Director, VA Great Lakes Health Care System (10N12)

Subject: **Combined Assessment Program Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan**

To: Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH/KC)

Director, Management Review Service (10B5)

I have reviewed the attached action plan submitted by the Oscar G. Johnson VA Medical Center. We will work with the medical center to ensure closure of all recommendations.

Renee Oshirski

for and in the absence of
Jeffrey A. Murawsky, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 15, 2009

From: Director, Oscar G. Johnson VA Medical Center (585/00)

Subject: **Combined Assessment Program Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan**

To: Director, VA Great Lakes Health Care System (10N12)

1. I have reviewed and concur with the recommendations of the Office of Inspector General. The Oscar G. Johnson VA Medical Center is proceeding with the completion of the following attached action plan.

2. The professionalism and consultative manner demonstrated by your team during this review process was appreciated by all.

(original signed by:)
Michael J. Murphy, FACHE

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 the VISN Director ensure that the Medical Center Director establishes a process for tracking and trending results of medical records reviews.

Concur **Target Completion Date: November 13, 2009**

Action Plan: Samples of medical record reviews have been obtained from other facilities and have been utilized to create our review elements. A monitor sheet will contain the elements for review. Performance Improvement will oversee the monitoring of inpatient and outpatient medical records at the point of care. Restraint use, provider orders, and problem lists continue to be reviewed for timeliness and compliance with Joint Commission standards and VHA policy. These monitors will be reported to the Medical Records Committee and to the Continuous Survey Readiness Committee, which contains a senior leadership component.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that patient care equipment be regularly inspected and that items with compromised surfaces be repaired or removed from service.

Concur **Target Completion Date: October 25, 2009**

Action Plan: Patient care equipment has been added to the EOC Committee rounds beginning September 15, 2009. This will be noted on the EOC Rounds tracking spreadsheet and will be reported quarterly to the EOC Committee by the chair of EOC rounds. Equipment with compromised surfaces identified during the OIG survey was immediately brought to Engineering for repair. Ten new wheelchairs have been ordered. The health aide on the inpatient unit routinely cleans and inspects all wheelchairs and brings them to Engineering for repair of compromised surfaces when identified.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that sensitive patient information be secured.

Concur **Target Completion Date: October 30, 2009**

Action Plan: Ongoing staff education on maintaining protected patient information was provided via an all employee e-mail on September 16, 2009, and had previously been sent on February 10, 2009. The Privacy Officer makes weekly rounds that encompass all areas in the medical center quarterly which began in January 2009. A spreadsheet is maintained by the Privacy Officer of the areas reviewed, findings, and corrective action plans. The reports will be presented quarterly at the Continuous Survey Readiness Committee. EOC rounds also include surveillance of patient sensitive information by both the Information Security Officer and the Privacy Officer and will be reported to the Continuous Survey Readiness Committee.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that sharp items be secured.

Concur **Target Completion Date: October 30, 2009**

Action Plan: The Associate Director for Nursing and Patient Care Service discussed immediately during the time of survey with ED, CLC, and surgery staff and their Nurse Managers the need to assure all sharps are secured. Ongoing staff education via an all employee e-mail will be provided by September 18, 2009. Security of sharp items is monitored during EOC rounds and will be reported to the EOC Committee and the Continuous Survey Readiness Committee. Managers develop and implement corrective action plans addressing any deficiencies noted.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete intra-facility transfer documentation in accordance with medical center policy.

Concur **Target Completion Date: December 4, 2009**

Action Plan: The nursing template for transfers has been updated and includes who the hand off report was provided to. The nursing template now includes all elements required by medical center policy. Providers were re-educated by the Chief of Staff on the need to include who a hand off report was provided to in their documentation on September 15, 2009. Ten records per month will be reviewed by Performance Improvement staff to monitor the requirements for transfers. That data will be reported to the Medical Records Committee and Continuous Survey Readiness Committee.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation in accordance with VHA policy.

Concur **Target Completion Date: December 31, 2009**

Action Plan: All providers were re-educated on the requirements for discharge instructions according to the requirements in Handbook 1907.01 including date, type of discharge, diagnosis, medication, diet, exercise, limit of disability, condition on discharge, place of disposition, and return follow-up on September 15, 2009. The providers have a discharge template to follow. Ten charts per month will be reviewed by Medical Records staff and this monitor will be reported to the Medical Records Committee and Continuous Survey Readiness Committee monthly until compliance is reached at 90%.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently assess and document pain medication effectiveness within the timeframe specified by medical center policy.

Concur **Target Completion Date: December 4, 2009**

Action Plan: The Nursing Service Policy was reviewed, and the time was changed from 2 hours to 4 hours for nursing staff to document pain medication effectiveness. The BCMA Coordinator will provide a weekly report to the Nurse Managers regarding compliance with nursing service policy. Action plans will be developed and tracked to completion by the Nurse Managers for those areas not meeting the 90% compliance rate. A weekly summary will be provided to the Associate Director for Nursing and Patient Care Service. This monitor will be reported to the Continuous Survey Readiness Committee monthly by the Associate Director for Nursing and Patient Care Service/designee.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that the OPPE plan, OPPE data, and the privileging process are managed in accordance with VHA requirements.

Concur **Target Completion Date: December 4, 2009**

Action Plan: A draft policy has been written and shared with service chiefs of providers. The final policy will be published after comments are reviewed by October 2, 2009. Ongoing Professional Practice Evaluation sheets have been in use and have been updated to include service-specific competency criteria. The Clinical Executive Board minutes will be written to include the discussion of performance data beginning with the September minutes.

OIG Contact and Staff Acknowledgments

Contact	Paula Chapman, CTRS, Associate Director Chicago Office of Healthcare Inspections (708) 202-2672
Contributors	Lisa Barnes, MSW Judy Brown James Seitz, BSN, MBA, RN Roberta Thompson, MSW John Brooks, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Great Lakes Health Care System (10N12)
Director, Oscar G. Johnson VA Medical Center (585/00)

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: Russell D. Feingold, Herb Kohl, Carl Levin, Debbie Stabenow
U.S. House of Representatives: Steve Kagen, David R. Obey, Bart Stupak

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