Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02952-498

Healthcare Inspection

Quality of Care Concerns in a Diagnostic Evaluation Jesse Brown VA Medical Center Chicago, Illinois

September 29, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a confidential complainant relating to quality of care concerns in a diagnostic evaluation at the Jesse Brown VA Medical Center (facility) in Chicago, IL.

The complainant alleged that a provider placed a consult for a vascular laboratory study for the patient to be completed within 72 hours, but it was not performed. The study was not scheduled for 5 months at which time, an appointment was arranged for the study to be completed 7 weeks later. The study was performed urgently when the patient presented to the facility's Emergency Department for complications related to peripheral vascular disease about 5-½ months after the consult was placed. The patient subsequently underwent an above knee amputation of the right leg, which the complainant alleges could have been prevented.

We substantiated a delay in scheduling and completing the lower extremity arterial study. Vascular laboratory staff did not notify the ordering provider of the scheduling delay, and managers did not utilize services from another VA or schedule non-VA care to obtain the study.

We could not substantiate the allegation that the patient's requirement for limb amputation would have been different had he received the vascular laboratory lower extremity arterial study sooner. The patient's lower extremity peripheral vascular disease (PVD) condition was eventually demonstrated to involve both proximal (large) and distal (small) arteries, making limb sparing options problematic if surgery was to become necessary. In many cases of lower extremity PVD, the obstructing process primarily affects the larger, proximal arteries allowing a "by-pass" procedure to accomplish bloodflow to lesser affected distal vessels. In other cases, as here, PVD is more diffuse and involves proximal and distal circulation, and merely bypassing a large proximal artery is of limited benefit, as there is "no good distal target" to accommodate greater blood flow.[1] While we could not substantiate that the patient's requirement for limb amputation would have been different had he received the vascular study sooner, we did determine that the delay complicated this patient's clinical course.

Although not an allegation, we identified an additional quality of care issue with this patient's care. During three providers' visits the patient did not receive complete pain assessments. If a patient's pain score is four or greater and/or the pain is unacceptable to the patient, a more comprehensive pain assessment will be performed. The patient's pain scores were documented between 8 and 10 during each of the three providers' visits. We found no documented evidence that a more comprehensive pain assessment was performed.

[1] Beard, Jonathan D., Chronic Lower Limb Ischaemia. *BMJ* 2000; 320; 854–957.

We recommended that the Facility Director:

- Evaluate the scheduling process for vascular consultations and diagnostic tests, and take action if factors potentially impacting quality of care are identified.
- Evaluate the practice of vascular laboratory technicians interpreting the urgency of providers' consult requests and whether providers are notified when consult requests are not scheduled within the providers' timeframe, and take action if needed.
- Ensure that managers develop a policy defining who is responsible for provider and patient notification of consults ordered through the Emergency Department or Urgent Care Clinic that are not completed timely according to VHA policy.
- Ensure that providers perform comprehensive pain assessments according to VHA policy, and monitor compliance.
- Ensure that managers conduct an internal evaluation of the case discussed in this report.
- Consult with Regional Counsel regarding possible institutional disclosure.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. According to the facility Director, an Institutional Disclosure was completed on June 26, 2015. (See Appendixes A and B, pages 9–13 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a confidential complainant relating to quality of care concerns in a diagnostic evaluation at the Jesse Brown VA Medical Center (facility) in Chicago, IL.

Background

The facility is part of Veterans Integrated Service Network (VISN) 12 and serves a veteran population of approximately 62,000 throughout the Chicago area and four counties in Northwestern Indiana. The facility operates 200 tertiary care beds in the areas of medicine, surgery, mental health, rehabilitation, neurology, and geriatrics. The facility is affiliated with the University of Illinois College of Medicine and Northwestern University's Feinberg School of Medicine.

Allegations

In April 2014, the OIG Hotline Division received allegations from a confidential complainant relating to quality of care concerns in the diagnostic evaluation of a patient with suspected peripheral vascular disease (PVD) at the facility. Specifically, the areas of concern were:

- A patient was seen for pain in his right lower extremity, and a vascular laboratory lower extremity arterial study[2] was ordered to be completed within 72 hours. The study was not done for more than 5 months.
- The patient underwent a right above knee amputation[3] that could have been prevented.

Scope and Methodology

The period of our review was May 2, 2014, to January 23, 2015. We conducted site visits on August 12–13 and August 27, 2014.

In August 2014, we interviewed the complainant by telephone to clarify the allegations. During our site visits, we toured the vascular laboratory and interviewed managers and administrative, clinical, and support staff with direct knowledge of the patient's care as well as facility practices.

[2] The request for a "vascular lab arterial study/lower extremity" equates to performance of an "ankle-brachial index." This is a non-invasive method to assess for peripheral vascular disease (that is, narrowing or blockage of arteries in the legs). The test compares (in a ratio) the blood pressure value measured at the ankle with that measured at the arm. Normally, the blood pressure at the ankle is the same as, or slightly more than, the blood pressure at the arm. An abnormal result (ratio) is a value of 0.9 or lower. A value of less than 0.5 suggests severe peripheral vascular disease.

[3] Amputation is the surgical removal of all or part of a limb or extremity such as an arm, leg, or foot.

We reviewed relevant Veterans Health Administration (VHA) and facility policies and procedures related to patient assessments and evaluations, scheduling for diagnostic testing, and patient notification of test results. We also reviewed the patient's VHA electronic health record and quality management documents relating to the patient's care. We requested and reviewed information regarding vascular laboratory lower extremity arterial studies performed at other VHA facilities or through non-VA care from July 1, 2013, through December 31, 2013.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

At the time of our review, the patient was in his late sixties with a history of hypertension, plantar fasciitis, and chronic tobacco use. In July 2013, the patient presented to the facility's Urgent Care Clinic (UCC) for right foot pain of 1 week's duration. He characterized the pain as severe ("10 out of 10") and noticeable with activity but also at rest. The UCC physician's examination documented the right foot to be "cold compared to the left," with darker skin over the distal right foot, with no arterial pulses present in the right foot, and normal pulses in the left foot.

The UCC physician's assessment was "claudication."[4] The patient was advised to discontinue smoking, and a consult was entered to undergo a "vascular laboratory lower extremity arterial study within 72 hours." The patient was also assigned a primary care provider (PCP) to follow up on issues identified in the UCC and for ongoing general medical care.

Approximately 2 weeks later, the patient was evaluated by the newly assigned PCP who commented, "the main reason for the visit is to follow up on foot pain." The PCP noted the patient's recent UCC visit and the UCC physician's consult request for a vascular laboratory arterial study. Lower extremity skin color, temperature, and pulses (all recorded as abnormal during the UCC visit 2 weeks earlier) were not documented. The PCP's assessment was "likely plantar fasciitis" but also cited was a "concern for PVD (peripheral vascular disease)." The vascular laboratory study requested by the UCC physician 2 weeks earlier was incorporated as part of the PCP's plan to further assess the patient. The vascular laboratory consult request, however, remained unscheduled. The PCP entered a routine consult for the Podiatry Clinic.

A Primary Care clinic nursing progress note that was entered into the VHA electronic health record in August, described the patient as having developed difficulty walking because of "20/10 pain in the right foot." The patient also described that he "cannot sleep" due to the distraction of the foot pain.

In November 2013, the patient was seen as a "new patient" in the Podiatry Clinic for a chief complaint of "right foot/ankle pain." The assessment by the Podiatry Clinic resident, with concurrence by the staff podiatrist, included PVD. The podiatry plan also cited the need for the lower extremity arterial study; however, a repeat request for a lower extremity arterial study was not entered.

In December, an appointment was scheduled for the lower extremity arterial study to be completed 7 weeks later at the facility's vascular laboratory.

However, 8 days after the appointment was made for the lower extremity arterial studies, the patient sought care in the facility's Emergency Department (ED) for

[4] Claudication is pain, usually affecting the lower extremity (ies), most often caused by insufficient blood flow (that is, peripheral vascular disease). Pain may be noticeable only with exercise, or, when PVD is more advanced, also present at rest.

continuing right foot pain, describing the pain as now being present "all the time," with difficulty bearing weight on the foot. Physical examination revealed the new finding of an ulcerated skin lesion with necrotic (non-viable) tissue over the top of the right foot. Vascular surgeons, seeing the patient that day for the first time, cited "concern for arterial insufficiency" and noted that the patient "never had a vascular evaluation of the extremities." The patient was admitted to the hospital for pain and "an expedited work-up" of lower extremity circulation status. The vascular laboratory study was performed on the day of admission and was consistent with severe PVD of the right lower extremity.

In addition, a computed tomographic angiography (CTa)[5] of the lower extremities was also completed on the day of admission and was consistent with severe vascular occlusive disease of the right lower extremity. During his first day in the hospital, the patient was noticed to have a right facial droop and ultimately shown to have had a stroke.[6]

Following recuperation from a stroke, and due to worsening pain with an enlarging necrotic skin lesion of the right foot, the patient underwent a right above knee amputation in February 2014. Because of a prolonged non-ambulatory state, a contracture of the right knee had formed and necessitated an above knee, rather than below knee, amputation.

Inspection Results

Issue 1: Scheduling Delay

We substantiated the allegation of a delay in obtaining the lower extremity arterial study. The patient was seen in the UCC in July 2013, and the provider placed a consult request for a lower extremity arterial study to be completed within 72 hours. The study was not scheduled for 5 months, at which time, an appointment was arranged for the study to be completed 7 weeks later. The study was completed urgently during an ED visit.

According to VHA policy,[7] the provider's specified timeframe for an appointment needs to be the date of the provider's request, unless otherwise specified by the provider, and if there is a discrepancy between the patient and the provider's desired date, the scheduler must contact the provider. Vascular laboratory staff did not notify the ordering provider of the scheduling delay, and managers did not utilize services from another VA or schedule non-VA care to obtain the study.

[5] Computed tomographic angiography (CTa) is a type of specialized imaging (x-ray) used to visualize blood vessels throughout the body. Among its uses is helping to detect atherosclerotic disease that has narrowed the arteries to the legs.
[6] A stroke occurs when circulation to a part of the brain is interrupted.
[7] VHA Directive 2010-027. *VHA Outpatient Scheduling Processes and Procedures*. June 9, 2010. This Directive expired June 30, 2015, and has not yet been updated.

Facility policy[8] requires the ordering provider to request non-VA care when timely services are unavailable through VA. According to VHA policy, non-VA care may be utilized when service is not available in a timely manner within VHA due to capability, capacity, or accessibility. VHA requires the facility to ensure that standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning. Use of non-VA care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality.[9]

We requested information regarding patients who had vascular laboratory lower extremity arterial studies performed at other VHA facilities or through non-VA care from July 1, 2013, through December 31, 2013. Facility managers informed us that during this timeframe no patients were authorized for vascular laboratory extremity arterial studies to be completed outside of the facility.

According to VHA policy, the Facility Director is responsible for ensuring that a written policy regarding communication of results from diagnostic practitioner to ordering practitioner is in place.[10] In addition, the Chief of Staff is responsible for ensuring that the ordering practitioner follows up on any order which they have placed. The providers we interviewed were not fully aware of who was responsible for notifying this patient of tests that were ordered by an ED or UCC provider and not completed timely. Facility managers did not have a policy addressing this specific circumstance.

Issue 2: Above Knee Amputation

We could not substantiate the allegation that the patient's requirement for limb amputation would have been different had he received the vascular laboratory lower extremity arterial study sooner. The patient's lower extremity PVD condition was eventually demonstrated to involve both proximal (large) and distal (small) arteries making limb sparing options problematic if surgery was to become necessary. In many cases of lower extremity PVD, the obstructing process primarily affects the larger, proximal arteries allowing a "by-pass" procedure to accomplish bloodflow to lesser affected distal vessels. In other cases, as here, PVD is more diffuse and involves proximal and distal circulation and merely bypassing a large proximal artery is of limited benefit as there is "no good distal target" to accommodate greater blood flow.[11]

While we could not substantiate that the patient's requirement for limb amputation would have been different had he received the vascular study sooner because of the nature of his underlying disease process, we did determine that the delay complicated this patient's clinical course including the extent of the procedure that was ultimately proposed and performed.

[8] Medical Center Memorandum No. 11-42-14, *Fee Basis Referrals*, November 23, 2011.
[9] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[10] VHA Directive 2009-019. *Ordering and Reporting Test Results*. March 24, 2009. This Directive expired March 31, 2014, and had not yet been updated.
[11] Beard, Jonathan D., Chronic Lower Limb Ischaemia. *BMJ* 2000; 320; 854–957.

Initial clinical suspicion of the patient's PVD was documented in July 2013 following 1 week of right foot pain. At that time, the UCC physician placed a consult for a "vascular laboratory lower extremity arterial study within 72 hours." During the next 5 months, no action was taken on the consult request, and the ordering UCC provider was not notified of the scheduling delay.

Furthermore, during the 5-month delay, the need for the study was referenced and endorsed by several providers. When the vascular study was scheduled, an appointment was made for 7 weeks later. About 1 week after the vascular study appointment was made, the patient presented to the ED because of a worsening of his symptoms with rest pain[12] and a necrotic right foot ulcer. The patient was evaluated for the first time by vascular surgery providers during this ED visit.

As a result of ongoing, worsening right foot pain, the patient had become non-ambulatory. By February 2014, he had developed a flexion contracture at the right knee. Though initially scheduled for a below knee amputation, vascular surgery revised the recommended procedure to an above knee amputation because of the patient's knee contracture. Lower extremity amputation at any level impacts functional outcomes, but the magnitude of the effect appears to be directly related to the extent of the amputation.

A below knee amputation is associated with lower energy expended with prosthetic use and results in better ambulation rates than above knee amputations. The maximum aerobic capacity in groups with vascular or traumatic above knee amputations has been documented as significantly lower than in groups with below knee amputations or normal subjects.[13] At 1-year follow-up, above knee amputees are less likely to ambulate (with or without assistance) and are more likely to use a wheelchair and require nursing home living than below knee amputees.[14]

During our interviews, vascular laboratory staff reported the UCC provider's consult request in July 2013 for a lower extremity arterial study within 72 hours was intended as a preliminary study to screen the patient for possible referral to the Vascular Surgery Clinic. The facility's service agreement for vascular surgery states that, to be seen, "patients must have arterial non-invasive lower extremity studies completed within the past 6 months prior to clinic visit." Patients without studies completed in the past 6 months will be scheduled by the clinic staff to have the studies completed prior to being scheduled for the clinic.

In this case, the process for obtaining desired clinical information proved dysfunctional. The UCC provider, whose vascular laboratory lower extremity arterial study consult request was based on the patient's history and physical examination, was not

[12] As a clinical finding, rest pain raises the concern of a severe decrease in limb perfusion, that is, the arteries of the leg can no longer deliver adequate blood flow to the feet, even at rest.
[13] Waters RL, Perry J, Antonelli D, and Hislop H, Energy Cost of Walking of Amputees: The Influence of Level of Amputation. *J Bone Joint Surg Am*, 1976 Jan; 58 (1): 42–46.
[14] Suckow, BD, Goodney, PP, Cambria, RA, Bertges, EF et al: Predicting Functional Status Following Amputation After Lower Extremity Bypass. *Ann Vasc Surg* 2012; 26(1):67–78.

successful in scheduling an appointment and remained uninformed as to the scheduling delays. During the 5-month delay from consult requested to appointment being scheduled, the patient's clinical course became more complex, as he developed extensive gangrene of the right foot. The vascular surgery team did not consider the patient a candidate for re-vascularization as a result of the diffuse, extensive nature of ischemia which precluded saving the patient's limb. Therefore, amputation became a necessary consideration. It is uncertain whether the lack of response by the vascular laboratory staff to a physician's consult request in July 2013 ultimately affected the patient's need for amputation; however, it may have been the basis for amputating above the patient's right knee rather than below it.

Issue 3: Quality of Care Issue

During the course of our review, we identified an additional quality of care issue with this patient's care. Providers did not perform comprehensive pain assessments as required by facility policy.[15] Prior to the ED visit, when the vascular study was performed urgently, the patient received incomplete pain assessments during three providers' visits beginning in July 2013 through November 2013. According to the facility policy, pain assessments and documentation will occur for all patients through initial interviews during clinic visits or on admission. If a patient's pain score is four or greater and/or the pain is unacceptable to the patient, a more comprehensive pain assessment will be performed. Also, a Pain Intensity Rating Scale is utilized when patients are able to verbally report pain with a scale of 0 to 10 with 0 indicating no pain and 10 indicating maximum pain.

The patient's pain scores were documented between 8 and 10 during each of the three provider visits. We found no documented evidence that more comprehensive pain assessments were performed. Comprehensive pain assessments may include, but are not limited to, the following information: onset, duration, location, quality or patterns of radiation, alleviating and aggravating factors, management history, and the patient's pain goals.

Conclusions

We substantiated the allegation of a delay in scheduling and completing the lower extremity arterial study. We could not substantiate the allegation that the patient's outcome would have been different had he received the vascular laboratory study sooner. However, we did determine that the delay in diagnosis complicated this patient's clinical course and potential functional outcome.

Although not an allegation, we identified an additional quality of care issue with this patient's care. During three providers' visits the patient did not receive complete pain assessments.

[15]Medical Center Memorandum 11-25-15, *Pain Management Policy*, April 06, 2012.

Recommendations

1. We recommended that the Facility Director evaluate the scheduling process for vascular consultations and diagnostic tests and take action if factors potentially impacting quality of care are identified.

2. We recommended that the Facility Director evaluate the practice of vascular laboratory technicians interpreting the urgency of providers' consult requests and whether providers are notified when consult requests are not scheduled within the providers' timeframe and take action if needed.

3. We recommended that the Facility Director develop a policy defining who is responsible for provider and patient notification of consults ordered through the Emergency Department or Urgent Care Clinic that are not completed timely according to Veterans Health Administration policy.

4. We recommended that the Facility Director ensure that providers perform comprehensive pain assessments according to Veterans Health Administration policy and monitor compliance.

5. We recommended that the Facility Director conduct an internal evaluation of the case discussed in this report.

6. We recommended that the Facility Director consult with Regional Counsel regarding possible institutional disclosure.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 22, 2015

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

Subj: **Healthcare Inspection—Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois**

To: Director, Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the completed response.
2. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans and families at Jesse Brown VAMC.

(original signed by:)

James W. Rice

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 15, 2015

From: Director, Jesse Brown VA Medical Center (537/00)

Subj: **Healthcare Inspection—Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois**

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Health Care team for their professional and comprehensive health care review conducted on August 12-13 and 27, 2014.

2. I have reviewed the draft report for the Jesse Brown VA Medical Center and action plans are provided for the recommendations.

3. I appreciate the opportunity to submit this response in support of continuous improvement in the health care services provided for our Veterans.

(original signed by:)

Ann R. Brown

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director evaluate the scheduling process for vascular consultations and diagnostic tests and take action if factors potentially impacting quality of care are identified.

Concur

Target date for completion: September 1, 2015

Facility response: The Vascular Service Agreement was updated in December 2014 and April 2015. These updates expounded on provider responsibilities. The service agreement and consult templates require the ordering providers who are requesting emergent, urgent or non-routine consults to contact a member of the Vascular Team (APRN, Vascular Fellow or Vascular Attending). Additionally, the service agreement identifies patient conditions that would necessitate the ordering of urgent consults. The Vascular Nurse Practitioner monitors compliance with the use of emergent/STAT and routine testing requests. Monitoring of the process will continue until sustainment of the improved scheduling process is achieved as evidenced by 90% compliance for three consecutive months.

Recommendation 2. We recommended that the Facility Director evaluate the practice of vascular laboratory technicians interpreting the urgency of providers' consult requests and whether providers are notified when consult requests are not scheduled within the providers' timeframe and take action if needed.

Concur

Target date for completion: October 31, 2015

Facility response: Service agreements and the order sets updates have been updated and beginning in December 2014, the Vascular Nurse Practitioner and/or the Vascular Lab Medical Director review all consults and determine the urgency of providers' consults on a daily basis. Vascular technicians do not evaluate the urgency of requests for Vascular studies.

Recommendation 3. We recommended that the Facility Director develop a policy defining who is responsible for provider and patient notification of consults ordered through the Emergency Department or Urgent Care Clinic that are not completed timely according to Veterans Health Administration policy.

Concur

Target date for completion: October 31, 2015

Facility response: A draft policy has been completed and is currently being reviewed by facility leadership. The policy will be distributed and providers will be educated after leadership approval. If a patient is a no-show, a CPRS alert is sent to the ordering provider. The ordering provider will consult with the Vascular Attending to determine the clinically appropriate rescheduled appointment date and will notify the Vascular Clinic clerk to call the patient to reschedule. The pending consult list is being run daily to ensure that all patients are scheduled appropriately.

The Vascular Lab telephone is now on the audio care system which generates a reminder call to the patients regarding upcoming appointments. Additionally a designated telephone line was added for Vascular Lab patients to call with questions. A dedicated staff member from vascular lab is available to respond to any messages from patients Monday through Friday. A full time clerk was designated for the vascular lab to answer telephones and which improves access for patients and allows for improved services for providers and other departments throughout the system. Audits of Emergency Department and Urgent Care Clinic demonstrate 90% compliance with completion of timely diagnostic tests for 3 consecutive months.

Recommendation 4. We recommended that the Facility Director ensure that providers perform comprehensive pain assessments according to Veterans Health Administration policy and monitor compliance.

Concur

Target date for completion: September 1, 2015

Facility response: Utilization of the numeric pain rating system (0-10) or Wong-Baker "faces" pain scale for pain screening is completed at clinical visits at JBVAMC. If there is a pain score of ≥4 there must be a documented comprehensive pain assessment intervention or it is considered non-compliance. Audits have demonstrated comprehensive pain assessment completion at or above 90% compliance for four consecutive months. The Associate Chief of Staff for Ambulatory Care and the JBVAMC Pain Committee have provided education to all primary and specialty care Patient Aligned Care Team (PACT) members to reinforce the need for comprehensive review of pain assessments. Information will also be discussed at staff meetings by July 2015.

Recommendation 5. We recommended that the Facility Director conduct an internal evaluation of the case discussed in this report.

Concur

Target date for completion: October 31, 2015

Facility response: An analysis of the incident was completed post-visit and system improvements were implemented. These strategies are tracked and reviewed weekly

by an interdisciplinary team, including the Medical Center Director and Chief of Staff, with the Vascular Lab staff. Although not an inclusive list, this includes: 1) development of policies, procedures and clinical competencies for the Vascular Lab staff; 2) a designated staff member to provide daily oversight and establish clear guidelines for the Vascular Lab staff; 3) a process for ensuring that all consults were received and processed in a timely manner; and 4) a formalized organizational chart, clarifying the reporting structure and roles of the Vascular Lab staff, was developed and signed by the Medical Center Director.

Recommendation 6. We recommended that the Facility Director consult with Regional Counsel regarding possible institutional disclosure.

Concur

Target date for completion: Completed

Facility response: The Chief of Vascular Surgery reviewed the facts of the case. The Chief of Staff and Medical Center Director consulted with Regional Counsel regarding the need for disclosure. It is the conclusion of facility leadership and Regional Counsel that an Institutional Disclosure will be completed. The disclosure was completed during the Veteran's clinic appointment on June 26, 2015.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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