VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System

November 9, 2016
14-02890-72

ACRONYMS

EHR	Electronic Health Record
FY	Fiscal Year
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OSC	Office of Special Counsel
PACT	Patient Aligned Care Team
SAVAHCS	Southern Arizona VA Health Care System
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Information Systems and Technology Architecture

Highlights: Review of Alleged Wait-Time Manipulation at VHA's SAVAHCS

Why We Did This Review

The Office of Special Counsel (OSC) referred allegations concerning the Southern Arizona VA Health Care System (SAVAHCS) Ocotillo Primary Care Clinic to the VA Secretary in October 2014.

These allegations were brought to the OSC by a former SAVAHCS employee who served in the Ocotillo Clinic. The complainant alleged that:

- Managers improperly directed scheduling staff to "zero out" patient wait times.
- [Ocotillo Clinic] physicians were awarded bonuses based in part on wait times.
- The complainant was excluded from a meeting with the hospital director.
- The failure to adhere to agency scheduling directives endangered veterans' health.

What We Found

The VA Office of Inspector General substantiated the OSC complainant's allegation that managers improperly directed scheduling staff to zero out patient wait times at the Ocotillo Clinic in violation of the agency's scheduling directive. Review of scheduling data showed 76 percent of appointments in the Ocotillo Clinic had a zero-day wait time from December 2013 through August 2014. According to a nursing supervisor, as well as nursing staff, SAVAHCS scheduler training taught methods that violated VA's national scheduling policy.

We partially substantiated that, in FY 2013, physicians were awarded bonuses based, to some extent, on appointment availability, including the percentage of patients scheduled within 14 days of their requested date. We found no evidence that Ocotillo Clinic physician performance pay in FY 2014, FY 2015, or FY 2016 was based on wait-time performance.

We did not substantiate that the complainant had been excluded from a meeting with the hospital director because the complainant criticized scheduling procedures.

Our review of patient care records found one patient who experienced a delay in care that led to a poor outcome. However, we determined that the poor outcome resulted from a lack of communication regarding the need for medical intervention, and not from SAVAHCS's failure to adhere to agency scheduling directives.

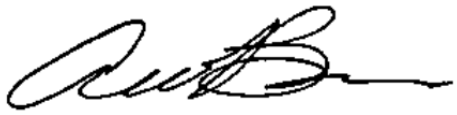
What We Recommended

We recommended that the VA Southwest Health Care Network Director:

- Review the training records of all SAVAHCS schedulers to ensure their training is compliant with Veterans Health Administration's (VHA) scheduling policy.
- Ensure that SAVAHCS schedulers comply with current VHA policy regarding scheduling policies and practices.

Management Comments

The Director of VISN 22 concurred with our findings and recommendations, and submitted acceptable corrective action plans. We will follow up on the recommendations to ensure full implementation of all corrective actions.



ANDREA C. BUCK
Chief of Staff for
Healthcare Oversight Integration

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INTRODUCTION

Objective

The Office of Inspector General (OIG) evaluated allegations forwarded by the Office of Special Counsel (OSC) regarding the Ocotillo Primary Care Clinic (Clinic) located at the Southern Arizona VA Health Care System (SAVAHCS).

OSC Allegations

OSC requested VA investigate allegations that officials at the Clinic may have engaged in actions constituting violations of law, rule, regulation, and a substantial and specific danger to public health. The allegations were brought to the OSC by a former employee who worked in the Clinic in early 2014. The OIG completed a related criminal case investigation, which was previously sent to the Office of Accountability and Review, and agreed to review independently these allegations. As VA OIG's criminal investigation neared conclusion, the OIG initiated a separate review in April 2016 to evaluate the allegations received from OSC. Using a multidisciplinary team from the Office of Audit and Evaluations and the Office of Healthcare Inspections, the VA OIG reviewed these allegations and conducted a site visit from April 12 through 15, 2016.

Interview With Complainant

On April 11, 2016, prior to visiting SAVAHCS, VA OIG staff interviewed the OSC complainant concerning the allegations. This was intended to verify the scope and nature of her August 2014 claims. The complainant confirmed she had referred the following allegations to OSC for its review:

- Managers improperly directed scheduling staff to "zero out" patient wait times at the Ocotillo Clinic, in violation of the agency's scheduling directive.
- Physicians were awarded bonuses based in part on appointment availability, including the percentage of patients scheduled within 14 days of their requested date.
- The complainant was excluded from a meeting with the hospital director because the complainant criticized scheduling procedures.
- The failure to adhere to the agency scheduling directive delayed medical appointments endangering the health of veterans seeking treatment at the facility.

RESULTS AND RECOMMENDATIONS

Finding 1 Did SAVAHCS Managers Improperly Direct Scheduling Staff To "Zero Out" Patient Wait Times?

OSC's complainant first alleged that, in early 2014, managers improperly directed scheduling staff to zero out patient wait times at the Clinic, in violation of the agency's scheduling directive. VA OIG first initiated a criminal investigation to determine whether there was evidence of criminal activity surrounding the facility's scheduling practices. At the end of the criminal investigation, VA OIG initiated a separate review to evaluate the allegations referred from OSC.

Criteria

The Veterans Health Administration (VHA) calculates wait times based on how long veterans must wait for an appointment from the date they wish to be seen (desired date). VHA Directive 2010-027[1] defines the veteran's desired date as follows:

- "The date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly."
- "The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date."

What We Did

VA OIG staff interviewed the former Chief of Primary Care, a nursing supervisor, and other nursing staff who worked in the facility during the time of the allegation. We also interviewed the Acting Medical Center Director and the Chief of Clinical Operations who oversaw training of medical schedulers including nursing staff. At the Clinic, nurses performed scheduling duties and all stated they received scheduling training, consistent with all other schedulers at the facility. We reviewed scheduling data from all appointments in the Clinic from December 2013 through August 2014. To determine if any changes to scheduling practices had occurred since the time of the complainant's allegations, we also reviewed scheduling data from October 2015 through March 2016. We further reviewed SAVAHCS scheduler training materials used to instruct the Clinic nursing staff on appropriate scheduling procedures, and management reports presented at SAVAHCS Patient Aligned Care Team (PACT) monthly steering committee meetings.

[1] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010.

What We Found

VA OIG substantiated that scheduling staff in the Clinic did zero out patient wait times for many patients. VA OIG staff reviewed 5,802 routine appointments within the Clinic from December 2013 through August 2014 and found that 76 percent of the appointments had the same date for the patient's desired date to be seen as the scheduled date. During VA OIG staff's interview with the complainant, she alleged that veterans would be offered the next available appointment when contacted. If a veteran agreed to accept the appointment, the desired date would be documented as the same date as the scheduled appointment in both Veterans Health Information Systems and Technology Architecture (VistA) and the veteran's electronic health record.

VA OIG staff interviewed three other nurses assigned to the Clinic who were instructed to use these scheduling practices. This instruction occurred prior to a series of town hall meetings the former SAVAHCS director held for all staff with scheduling privileges on May 9, 2014.

At these meetings, the former director stressed the need to always request that the veteran express his/her desired date and accurately document that date in the scheduling record. These meetings took place after the Phoenix VA Medical Center's scheduling problems were being reported in the media and prior to VHA's System-Wide Review of Access. A nursing supervisor stated that nurses were incorrectly trained by Business Service Line staff [2] to offer veterans the next available appointment and record that date as the patient's desired date. This practice was a violation of VA's scheduling policy.

VA OIG staff also reviewed Clinic scheduling data from October 1, 2015 through March 31, 2016. These data showed some improvement. The VA OIG determined that 2,212 out of 4,855 routine appointments (46 percent) during this period were scheduled on the same day as the date the patient desired to be seen. The percentage of appointments with matching patient desired dates and appointment dates declined significantly, almost 40 percent, from our previous review of December 2013 through August 2014 Clinic scheduling data.[3]

[2] Business Service Line was dissolved and SAVAHCS reorganized with Group Practice & Management Support Service Line responsible for scheduler training as of October 2015.

[3] Having 46 percent of appointments scheduled on the same day as the patient's desired date could mean that the scheduling practices are still not acceptable. However, we cannot be more definitive on the degree of unacceptable scheduling practices given the lack of integrity of the data. We were not able to determine a precise breakdown of appointments to know whether they were appropriate or whether schedulers were not following VHA policy in a meaningful manner. For example, if a patient is traveling and requests an appointment in 2 weeks, it would be appropriate to have an appointment on the same day that a patient desired to be seen. We will follow up on the current practices as part of the implementation of the recommendations.

Why This Occurred

VA OIG staff reviewed SAVAHCS scheduling training materials from early 2014 and found that the practice of recording the next available date for an appointment as the patient's desired date was included in the training provided to schedulers within the medical facility. The training materials instructed schedulers to document a veteran's desired date and presented mock scenarios in which a scheduler would explicitly request "When would you like to be seen?" before offering the veteran an appointment time. The veteran's response would be documented as the desired date. However, the training slides also contained a scenario in which the scheduler offers the veteran an appointment and the veteran accepts the appointment. The veteran is not requested to state a specific date he/she wishes to be seen. In this scenario, the training material indicated that the "agreed upon date becomes the desired date."

VA OIG staff also reviewed management reports presented at PACT monthly steering committee meetings. These meetings were attended by senior executive staff within the hospital. The reports tracked wait-time performance for each of the six Ocotillo providers. The providers were expected to have 92 percent of veterans seen within 7 days of the patients' desired dates. Several of the Ocotillo nurses we interviewed said the reports were distributed and discussed with them on a regular basis by leadership within Primary Care. One nurse claimed that leadership was very driven to meet these wait-time metrics and that she was told to "fix it" if she fell short of the performance goal without explicitly requesting scheduling records to be altered. The nurse claimed that there was no other way to meet these performance standards without manipulating a veteran's desired date.

VA OIG reviewed scheduler training materials used in FY 2016, and compared them with the materials used previously by the facility. We determined that FY 2016 materials had been changed to align with national VHA scheduling policy. The FY 2016 training materials instructed the scheduler to use the create date of the appointment as the patients desired date when scheduling the next available appointment in a clinic.

Conclusion

VA OIG substantiated the OSC complainant's allegation that managers improperly directed scheduling staff to zero out patient wait times at the Clinic during early 2014, in violation of the agency's scheduling directive. Review of scheduling data showed 76 percent of appointments in the Clinic had a zero-day wait time from December 2013 to August 2014. In addition, a nursing supervisor and several nursing staff stated that, in 2014, local scheduling training taught methods that violated VA's national scheduling policy. However, training materials for FY 2016 had been updated to reflect current VHA scheduling policy. While training materials have been corrected, the facility's scheduling data still reflected that 46 percent of patients' appointments occurred on the same day that they were scheduled.

Recommendations

1. We recommended the VA Desert Pacific Healthcare Network Director review the training records of all SAVAHCS schedulers to ensure their training is compliant with Veterans Health Administration scheduling policy.

2. We recommended the VA Desert Pacific Healthcare Network Director ensure that SAVAHCS schedulers comply with current VHA policy regarding scheduling policies and practices.

3. We recommended the VA Desert Pacific Healthcare Network Director perform an administrative investigation to determine who directed former Business Service Line officials to create and use training materials that did not comply with VA scheduling policy and take appropriate disciplinary action for any individuals involved.

Management Comments

The Veterans Integrated Service Network (VISN) 22 Director concurred with our findings and recommendations to ensure SAVAHCS schedulers receive appropriate training and comply with current VHA scheduling policies and practices. The VISN 22 Director's entire verbatim response is located in Appendix B.

OIG Response

The VISN 22 Director's planned corrective actions are acceptable. We will monitor VA's progress and follow up on the implementation of recommendations until proposed actions are completed.

Allegation 2 Were Ocotillo Clinic Physicians Awarded Bonuses Based in Part on Wait Times?

The OSC complainant also alleged that Ocotillo Clinic physicians were awarded bonuses based in part on appointment availability, including the percentage of patients scheduled within 14 days of their requested date.

Criteria

According to VA Handbook 5007, *Pay Administration*, revision dated April 2013, performance pay is defined as a component of compensation paid to recognize the achievement of specific goals and performance objectives prescribed, on a fiscal-year basis, by a medical facility director to a Primary Care physician. It is based on local performance goals that may be added to a series of national strategic objectives. VA medical facility chiefs of staff will make recommendations to facility directors on annual performance pay amounts.

What We Did

VA OIG staff interviewed the former Chief of Primary Care and a nursing supervisor. VA OIG staff also reviewed FYs 2013 and 2014 performance pay documentation for all Clinic physicians and nurses.

What We Found

VA OIG partially substantiated that physician bonuses were awarded based on wait-time metrics in FY 2013. OIG staff reviewed physician performance pay for the physicians assigned to the Clinic for FYs 2013 and 2014. In FY 2014, none of the Clinic physicians' performance pay was based on wait-time metrics.

Across all clinics, most performance pay metrics found in the physicians' personnel records for FY 2014 did not include access measures, with some explicitly stating that wait times were excluded from any calculation of performance per VA policy. In the Clinic specifically, there were two physicians who still had wait-time goals among their metrics, but the wait-time measures were not used in the calculation of their performance pay for FY 2014. In FYs 2015 and 2016, wait-time metrics were excluded from the calculation of performance pay entirely.

In FY 2013, four of the five Clinic physicians had clinic wait-time goals included in their metrics for determining performance pay. The wait-time goals were based on a physician's ability to see patients within either 7 or 14 days of their desired date. The wait-time metrics accounted for between 5 and 15 percent of the four physicians' performance pay in FY 2013. Performance pay for four of the five physicians assigned to the Clinic totaled $28,521 of which $3,257 (about 11 percent) related to wait-time performance.

During our interview with the complainant on April 11, 2016, and in addition to her original allegations regarding physician bonuses, she alleged that

nurses in the Clinic were receiving quarterly bonuses for manipulating scheduling records to meet wait-time performance goals.

VA OIG staff reviewed the personnel files of seven nurses assigned to the Clinic during FYs 2013 and 2014. Five of seven nurses received annual cash awards, collectively totaling $2,612 in FY 2014 and $3,296 in FY 2013. We found no evidence of quarterly awards or that the criteria for the awards were related to wait-time performance for these nurses.

Conclusion

VA OIG partially substantiated that physicians were awarded bonuses based, to an extent, on appointment availability, including the percentage of patients scheduled within 14 days of their requested date. VA OIG found no evidence that Clinic physician performance pay in FY 2014, FY 2015, or FY 2016 was based on wait-time performance. Wait-time performance was a limited factor in calculating FY 2013 physician performance pay and the use of wait-time performance goals to calculate performance pay was not prohibited by VA policy at the time. Therefore, as current practice does not link physician performance pay to wait times, the VA OIG made no recommendations.

Allegation 3 Was the Complainant Excluded From a Meeting With the Hospital Director?

The OSC complainant also alleged that she was excluded from a meeting with the former SAVAHCS hospital director on May 9, 2014 by her supervisor because the complainant criticized SAVAHCS scheduling procedures. During her April 11, 2016 interview with the OIG, the complainant stated that her supervisor had excluded her from a list of nurses she allowed to attend a town hall meeting on scheduling procedures hosted by the former hospital director on May 9, 2014.

What We Did

VA OIG staff interviewed the former Chief of Primary Care and a nursing supervisor. OIG staff also reviewed the complainant's time and attendance record for the pay period of the town hall meeting and a list of Primary Care nurses the complainant alleged were allowed to attend the town hall by her direct supervisor. OIG staff also interviewed seven Primary Care nurses with scheduling responsibilities: three whose names appeared on the alleged list of nurses allowed to attend the town hall meeting and four whose names were not on that list.

What We Found

OIG did not substantiate that the complainant was excluded from a meeting with the hospital director. The complainant gave OIG a list of names she alleged came from emails sent by her supervisor. She claimed that this list comprised a group of nurses her supervisor had approved to attend that town hall meeting. The list obtained from the complainant was not attached to an email nor did it contain headings or markings reflecting that it came from an email.

OIG staff identified seven nurses assigned to her supervisor. Three of these nurses appeared on the "approved list" obtained from the complainant and four did not appear on the list. OIG staff interviewed all seven nurses and each stated that they had attended the town hall meeting. None of the nurses interviewed from the Clinic stated that they were aware of anyone being excluded from attending the town hall meetings. The supervisor also denied barring anyone from attending the town hall meeting. In addition, none of the nurses interviewed admitted being aware that the complainant raised concerns about scheduling practices prior to the town hall meeting. Time and attendance records showed the complainant was on duty for her 8-hour shift on May 9, 2014 and should have been able to attend.

Conclusion

VA OIG found no evidence supporting the allegation that the complainant was prevented from attending a town hall meeting with the former SAVAHCS director because she criticized SAVAHCS scheduling procedures.

Allegation 4 Did the Failure To Adhere to Agency Scheduling Directives Endanger Veterans' Health?

The OSC complainant also alleged that the failure to adhere to the agency scheduling directive delayed medical appointments, endangering the health of veterans seeking treatment at the facility.

What We Did

VA OIG asked the Clinic complainant if she had specific examples of patients who may have been harmed by SAVAHCS staff's lack of adherence to agency scheduling policy. The complainant was not able to produce any specific examples for VA OIG to review. In reviewing the Clinic appointments that were scheduled from December 2013 through August 2014, VA OIG staff identified 13 veterans who had a total of 15 appointments with wait times exceeding 30 days who died before the appointment date. VA OIG staff identified these veterans by comparing scheduling data with Social Security death records. These veterans' cases were forwarded to OIG's Office of Healthcare Inspections (OHI) for review.

OHI inspectors reviewed each of the 13 veterans' VA electronic health records (EHRs). VA OIG verified the date of each canceled appointment, the date of creation and cancellation of the appointment, each patient's medical history, each patient's medical management near the date of death, and encounters available between the appointment creation date and the date of death. OHI inspectors then sought to answer the following questions:

(1) Was there evidence within VA's EHR when the appointment was created that any of the patients were requesting more immediate care or were in need of more immediate care?

(2) Did a delay between appointment creation and actual scheduled appointment adversely affect the patient's care?

What We Found

OHI inspectors found no evidence within the EHR that any of the 13 patients were seeking an immediate appointment or were in need of an immediate appointment at the time of their death. All of the canceled appointments were within the patients' PACT Clinics (12 appointments), the PACT Registered Nurse Clinic (1 appointment), and Infectious Disease Clinic (2 appointments). The two patients with scheduled appointments at the Infectious Disease Clinic were being followed for chronic issues and each of the appointments was made soon after their previous Infectious Disease Clinic appointment, as part of scheduled follow-up.

Based on the evidence in VA's EHR, OHI inspectors concluded that appointment delays did not adversely affect the patients' care. The 15 appointments for which veterans had wait times exceeding 30 days were made as part of routine follow-up. A majority of the patients had complex medical histories and were followed by several different subspecialty clinics.

In addition, many patients were being followed by community providers and primarily relied on SAVAHCS for prescription assistance.

Results of Prior SAVAHCS Investigation

While OHI inspectors did not identify any patients who died as a result of appointment delays, they did identify an instance of possible patient harm related to a delay in the implantation of a cardiac device. The results of this review may be found in VA OIG's prior administrative summary of its wait time investigation at this facility. Results from that investigation were sent to the Office of Accountability Review. However, that delay resulted from poor communication regarding the need to schedule the device implantation, not from improper scheduling.

Conclusion

A previous VA OIG investigation found that one patient experienced a delay in care due to poor communication, which led to a poor outcome. However, the investigation did not substantiate that the poor outcome was the result of SAVAHCS's failure to adhere to agency scheduling directives. In this report, the OHI inspectors' review of the 15 canceled appointments for patients who died while waiting more than 30 days for care, found no evidence that any of the veterans were in need of more immediate care within the Ocotillo Primary Care Clinic, the Ocotillo PACT Registered Nurse Clinic, or the Ocotillo Infectious Disease Clinic. The appointments were scheduled as routine follow-ups. Each patient's death, based on records available within VA's EHR as of May 11, 2016, appears to be related to complex chronic diseases that were being appropriately managed.

Appendix A Scope and Methodology

Scope

We conducted our review from April through August 2016. We reviewed scheduling practices that occurred in the SAVAHCS Ocotillo Primary Care Clinic in FY 2014, and compared them to current practice. We reviewed scheduling data for routine appointments completed in the Clinic from December 2013 through August 2014 and from October 2015 through March 2016. For purposes of our review, routine appointments are defined as any appointment that is not "high priority." VHA defines a high priority appointment as an appointment with a clinically indicated or preferred date within 7 days of the create date.

We also reviewed performance bonuses received by physician and nursing staff assigned to this clinic in FYs 2013 and 2014, and compared them with performance bonuses available during FYs 2015 and 2016. We interviewed 23 SAVAHCS current and former staff regarding the four allegations forwarded by the OSC to VA OIG in October 2014.

Government Standards

We did not perform this project in accordance with Council of the Inspectors General on Integrity and Efficiency's *Inspection and Evaluation Planning Standards*. However, we believe the scope of our review and the work completed was sufficient to support the findings and recommendations in this report.

Appendix B Management Comments

Department of Veterans Affairs Memorandum

Date: October 21, 2016

From: Southern Arizona VA Health Care System Medical Center Director (678/00)

Subject: Response to Draft Report, Review of Office of Special Counsel Allegations Concerning the Southern Arizona VA Health Care System (SAVAHCS)

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review and comment upon the draft report. SAVAHCS concurs with the recommendations 1, 2, and 3 in the draft:

Recommendation 1: We recommend that the VA Desert Pacific Health Care Network Director ensure the VA Southern Arizona Health Care Medical Center Director review the training records of all SAVAHCS schedulers to ensure their training is compliant with Veterans Health Administration scheduling policy.

VA Southern Arizona Health Care Medical Center Director Response: Concur.

As noted in the report, "The VA OIG reviewed scheduler training materials used in FY 2016 and compared them with the materials used previously by the facility. We determined that FY 2016 materials had been changed to align with national VHA scheduling policy. The FY 2016 training materials instructed the scheduler to use the create date of the appointment as the patients' desired date when scheduling the next available appointment in a clinic".

A review of all current scheduling key holders was completed which verified that all individuals are compliant with mandatory training requirements outlined in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* dated June 9, 2010. VHA has released an updated scheduling policy, VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* dated July 15, 2016, which requires additional training for scheduling key holders. The current TMS training scheduler modules are under construction and we are following VHA Access and Clinic Administration Program (ACAP) Office guidance, released August 2016, related to scheduler training in the interim. All schedulers received a copy of the new directive, and were directed to register for a local facility presentation of the ACAP National Scheduling Webinar, "Outpatient Scheduling Processes and Procedures VHA Directive 1230, Major Changes to the Scheduling Directive." All schedulers and scheduling key holders completed this training, and signed and certified they have read and understand the directive.

Recommendation 2: We recommend that the VA Desert Pacific Health Care Network Director ensure that VA Southern Arizona Health Care Medical Center Director ensures SAVAHCS schedulers comply with current VHA policy regarding scheduling policies and practices.

VA Southern Arizona Health Care Medical Center Director Response: Concur.

The Compliance Office performed bi-weekly monitors of SAVAHCS scheduling practices including: review of appointments scheduled on the exact same date of desired date; "zero wait" appointments and, percent of occurrences by scheduler to identify any outliers. Outliers were reported to the section chief for remediation and training. The Scheduling Trigger Tool has been implemented and it replaces this monitor.

SAVAHCS leadership conducts facility and CBOC rounds, which include a discussion of the scheduling processes and emphasis on scheduling integrity. The Group Practice Manager, accompanied by the Administrative Leads, also conducts rounding with the schedulers to emphasize the importance of scheduling accuracy and data reliability.

Recommendation 3: We recommend that the VA Desert Pacific Health Care Network Director ensure the VA Southern Arizona Health Care Medical Center Director perform an administrative investigation to determine who directed former Business Service Line officials to create and use training materials that did not comply with VA scheduling policy and take appropriate disciplinary action for any individuals involved.

VA Southern Arizona Health Care Medical Center Director Response: Concur.

The SAVAHCS will appoint an administrative investigative board (AIB). The scope and level of personnel actions necessary will be determined based upon the AIB findings and recommendations.

(Original signed by:)

Jennifer S. Gutowski, MHA, FACHE
Acting Director

For accessibility, the format of the original memo has been modified to fit in this document.

Appendix C OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Matthew Rutter Joshua Belew Dr. Julie Kroviak Erin Routh

Appendix D Report Distribution

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