Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00352-12

Healthcare Inspection

Administrative and Clinical Concerns Central California VA Health Care System

Fresno, California

November 2, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to address concerns received from Congressman Jim Costa in 2014 regarding allegations from an anonymous complainant of Emergency Department (ED)-boarded patients' length of stay (LOS), poor inpatient flow, and nurse staffing shortages at the Central California VA Health Care System (system), Fresno, CA. An anonymous complainant with similar allegations contacted the OIG Hotline in December 2013 and again in July 2014 and February 2015. We requested that system leaders respond to the allegations. In May 2015, they acknowledged issues with ED-boarded patients' LOS, inpatient flow, and registered nurse staffing, and implemented an action plan for improvement. The system's specific actions to address the identified issues follow.

ED Boarding

- Tabulate and track trends in patient flow and wait times on a monthly basis.
- Re-design the utilization management (UM) team structure.
- Designate a Patient Flow Coordinator.
- Designate a location for patient overflow during ED surges.
- Require the Transfer Coordinator to assist with transfers from the system ED to other VA or non-VA EDs.
- Establish written protocols to identify a process to transfer ED-boarded patients to available VA and non-VA facilities.
- Establish a float pool of nurses to assist with ED surges.

Inpatient Flow

- Require UM staff to review data, including bed utilization, to determine which bed types are needed.
- Increase the number of full-time UM employees to a total of 3.0 in April 2015.
- Purchase and install additional equipment on the medical/surgical unit to increase the number of telemetry beds.
- Purchase and utilize point-of-care phones on inpatient units.
- Implement a more robust discharge communication process at the provider level to decrease the inpatient average LOS by 0.6 days.
- Assemble a team of unit nurses, doctors, and social workers to review patients' discharge needs on inpatient units 5 days a week.

Nurse Staffing Concerns

- Supplement nurse staffing throughout the system with a new float pool of registered nurses.
- Utilize VA traveling and agency contract nurses to supplement staffing plans.

In January 2016, we conducted a review of the system's progress after 6 months (July 1, 2015 through December 31, 2015) of implementing their action plans. The purpose of this follow-up review was to determine if the system had fully implemented the action plans and if LOS for ED-boarded patients, inpatient flow, and nurse staffing had improved.

We found that system leaders did not implement 1 of the 15 action plan items related to ED boarding, inpatient flow, and nurse staffing. System leaders had not established written protocols to identify a process to transfer ED-boarded patients to available VA and non-VA facilities when acute inpatient beds were unavailable. In addition, the system's policy that addressed the designated location for ED patient overflow did not identify criteria for ED-boarded patients who could be transferred to the CLC.

A comparison of LOS boarded patient data before implementation of the system's action plan and after implementation in 2015 showed improvement but did not meet Veterans Health Administration (VHA) standards. The number of admitted patients' LOS less than 4 hours increased by 6 percent. However, 56 percent of boarded patients were still waiting greater than or equal to 4 hours. We also determined that the boarded patients' LOS greater than or equal to12 hours decreased by 10 percent, while the number of boarded patients staying greater than or equal to 4 hours but less than 12 hours increased by 4 percent.

System leaders had implemented actions to improve inpatient flow. We compared the VA Inpatient Evaluation Center LOS data for acute care for third quarter fiscal year (FY) 2015 to third quarter FY 2016 and found that the LOS had decreased by 1.08 days. Inpatient flow remained a challenge for system leaders due, in part, to the LOS for patients waiting on the acute care unit for community nursing home placement and the limited number of acute inpatient beds to meet the demand for these services. Although we found that system leaders were addressing these ongoing issues, more work is needed.

System leaders indicated in their May 1, 2015 response that it was routine policy to offer boarded patients a transfer to a VA or non-VA facility for inpatient care; however, their policies related to ED boarding did not provide guidance on offering boarded patients transfer to another facility for inpatient care. We reviewed 180 electronic health records (EHR) of boarded patients and found that 96 percent lacked documentation that the patient was offered a transfer to a VA or non-VA facility.

We reviewed the system's Registered Nurse (RN) staffing levels for the ED and the intensive care, step-down, and medical/surgical units. The total number of RN

vacancies had decreased to 5 as of January 28, 2016 from the previous 11 vacancies indicated in the system's May 11, 2015 response to the OIG.

In the course of our review, we identified a patient whose adverse outcome illustrated many of the challenges associated with ED-boarded patients who need to be transferred due to the lack of available inpatient beds. The patient presented to the ED on a day when the system and the local hospitals had no available inpatient beds. The patient was diagnosed with a rapid heart rate and alcohol withdrawal. In addition, the patient experienced a delay in transfer due to the unavailability of a nurse to accompany him, and the patient did not receive a reassessment to determine suitability for transfer. The patient died after a prolonged transport on the maximal dose of a medication generally used in critical care.

We determined that the following clinical and administrative factors might have contributed to the patient's death:

Clinical Factors

The ED physician did not:

- Re-evaluate the patient's response to a short acting heart rate lowering medication or consider alternative treatment strategies because the medication was not effective in lowering the patient's heart rate.
- Consult a cardiologist or an intensivist, or admit the patient to the system intensive care unit.
- Consider air ambulance transport, which would have shortened the duration of travel.

Administrative Factors

System leaders had not:

- Been sufficiently aggressive with moving boarded patients out of the ED to appropriate locations for the needed level of care.
- Identified an ED patient overflow area capable of taking telemetry patients.
- Negotiated transfer agreements or other protocols with local hospitals.
- Established an effective nurse float pool.

System clinicians performed peer reviews of this patient's care. Subsequently, the Veterans Integrated Service Network (VISN) Chief Medical Officer obtained a review from a cardiologist, who opined that the care was adequate. An institutional disclosure was not done.

An external administrative review to determine whether the system was adequately prepared to safely manage its patient volume may provide specific feedback to assist leadership.

Because the system failed to adequately correct ED patient flow and nurse staffing after becoming aware of issues in these areas, we have directed recommendations associated with this report to the VISN.

1. We recommended that the VISN Director ensure that system leaders establish written protocols to identify a process to transfer ED-boarded patients to available VA and non-VA facilities when acute inpatient beds are unavailable.

2. We recommended that the VISN Director ensure that the policy that designates the location for ED patient overflow includes criteria for boarded patients who can be placed in the community living center.

3. We recommended that the VISN Director ensure that a policy is developed and implemented to ensure that ED staff offer boarded patients transfer to a VA or non-VA facility for inpatient care and that ED staff document the offers and managers monitor compliance.

4. We recommended that the VISN Director ensure that managers continue to strengthen processes to improve boarded patients' LOS in the ED.

5. We recommended that the VISN Director ensure that ED providers reassess patients prior to transfer to confirm that patients are stabilized and suitable for transfer to the receiving unit.

6. We recommended that the VISN Director implement applicable recommendations from previous patient event-related reviews and monitor compliance.

7. We recommended that the VISN Director consult with the Office of Chief Counsel regarding whether an institutional disclosure might be appropriate.

8. We recommended that the VISN Director consider requesting an external administrative review to determine whether the system was adequately prepared to safely manage its patient volume.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 22–26, for the full text of the Directors' comments). We consider recommendations 4, 6, 7, and 8 closed. We will follow up on the planned actions for recommendations 1, 2, 3, and 5 until they are completed.

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

Purpose

VA Office of Inspector General (OIG) conducted a healthcare inspection to address concerns received from Congressman Jim Costa in 2014 regarding allegations from an anonymous complainant of Emergency Department (ED)-boarded patients' length of stay (LOS), poor inpatient flow, and nurse staffing shortages at the Central California VA Health Care System (system), Fresno, CA. The purpose of the inspection was to determine if system leaders had fully implemented an action plan submitted in May 2015 addressing such allegations and whether ED-boarded patients' LOS, inpatient flow, and nurse staffing had improved.

Background

The system is part of Veterans Integrated Service Network (VISN) 21. The system provides acute inpatient and outpatient care, and includes a community living center (CLC), and three community based outpatient clinics. The system's ED is a 24-hour a day emergency service staffed by physicians, nurses, and support personnel. The ED consists of 18 beds, the intensive care unit (ICU) has 6 beds, the step-down unit[1] has 7 beds (1 palliative care),[2] and the medical/surgical unit has 30 beds.

We received an initial complaint in December 2013 and similar complaints in July 2014 and in February 2015.

Timeline of Events

On December 27, 2013, we received an anonymous complaint with allegations that the System Director refused to fill nursing positions resulting in poor patient outcomes; beds were capped on inpatient units; patients were refused admission due to bed closure; and ED-boarded patients stayed in the ED for days.

We reviewed the allegations and requested a VISN level evaluation, and on May 29, 2014, the VISN Director provided a response. The VISN Director acknowledged that system leaders capped beds to maintain proper staffing requirements, and nursing managers did not recruit for numerous vacant nursing positions as they were undergoing an evaluation of staffing needs. The response stated that nursing vacancies did not result in any poor patient outcomes. The VISN Director indicated that patients were not refused admission because of bed closure; however, he acknowledged that some patients were staying in the ED greater than 23 hours, with an average time around 7 hours. In addition, the VISN Director indicated that system leaders had made significant efforts to enhance patient flow and initiated the following practice changes:

[1] A step-down unit provides intermediate care between that of an ICU and a medical/surgical unit.
[2] Palliative care is a term that includes hospice care as well as other care that emphasizes symptom control, but does not necessarily require the presence of an imminently terminal condition or time-limited prognosis.

- Front-line staff on the inpatient unit monitored barriers to discharge creating a continuous analysis to determine priority action areas regarding patient movement. This led to changes in social work staffing that appeared to have had an immediate impact on LOS. LOS decreased from 4.7 days to 3.8 days.
- The Patient Flow Committee was established to review ongoing processes.
- A Registered Nurse (RN) Patient Flow Coordinator was hired to assist across the entire process.
- A two-way communication hand-off process between inpatient and outpatient settings had improved and allowed for earlier discharges.
- Observation beds were established according to policy and procedure, and utilization of them increased significantly.
- Ongoing daily interdisciplinary meetings were held to determine ways to facilitate discharges.

On July 16, 2014, we received a letter from Congressman Jim Costa regarding allegations from an anonymous complainant that staff shortages presented risks to patient safety, a patient was boarded in the ED for 5 days, and boarded patients were waiting longer for an available inpatient bed. We reviewed the allegations and requested that system leaders evaluate and provide a response.

On February 18, 2015, the System's Acting Director responded to the allegations and acknowledged that there was no evidence of increased adverse patient outcomes due to nurse staffing shortages. System leaders stated that "patient care incidents are reviewed daily by the Quality Management team and various clinical leaders" and that "[a]cute care mortality rates have improved significantly in the last few years"; however, we did not receive data to confirm the statements.

System leaders did validate that patients were boarded for more than 24 hours in the ED. The Acting Director acknowledged that the challenges related to periodic ED patient backlog and inpatient bed availability in general were a problem and an action plan had been implemented; however, they did not provide data to validate. The response stated that the system tabulated and tracked trends in patient flow and wait times on a monthly basis, and that systems redesign and lean techniques[3] were used to drive improvement. The outcomes from the system redesign and lean techniques included:

- Re-design the utilization management (UM) team structure.
- Designate a Patient Flow Coordinator.
- Designate a location in the facility to use for patient overflow.

[3] Lean is a systematic approach to improving the reliability of processes through the identification and elimination of operational barriers and sources of variability within a process or system.

The response indicated that the system held a week-long Rapid Process Improvement Workshop (RPIW)[4] in late November 2014. The team recommended the following interventions:

- Assign a Transfer Coordinator to assist with ED to ED transfers.
- Build agreements with additional hospitals in the region that might accept overflow admissions.
- Establish a float pool of nurses to assist with ED surges.

The response also stated that since November 2014, system leaders took the following additional actions:

- Reviewed bed utilization data, which allowed leaders to look at which bed types were needed.
- Created a robust discharge communication process that decreased the average length of stay (ALOS) by 0.6 days.
- Purchased and installed telemetry equipment on the medical/surgical unit.
- Purchased point-of-care (POC) telephones that were assigned to nurses in primary care, the ED, and inpatient units.
- Created a meeting 5 days a week during which a team of nurses and social workers discuss inpatient discharge needs.

On February 26, 2015, the OIG Hotline Division received similar complaints regarding long ED LOS and continued nurse staffing shortages. We reviewed the allegations and requested that the system assess and respond to these ongoing concerns.

In a response to the OIG on May 11, 2015, the system's Acting Director acknowledged issues with LOS in the ED, and specifically responded to the finding that a patient waited more than 24 hours in the ED. The Acting Director indicated that:

> *…it was unclear why the patient was not transferred to another facility for care, or if it was offered. It is routine policy that the system ensures that the patient is offered a transfer of inpatient care to a VA or non-VA facility. Currently, the system works to ensure that this transfer opportunity is offered to all patients on a routine basis*.

In addition to acknowledging issues with LOS, the Acting Director also acknowledged issues[5] with inpatient flow and RN staffing, and advised us that an action plan had been implemented for improvement in each of these areas.

[4] An RPIW is an improvement workshop meant to pull together multiple employees from the organization to analyze and improve a complex, common process. An RPIW has a fundamental operational goal to create a more reliable, efficient, patient-driven process.

[5] At the time of the allegations and VHA response, there was an Acting System Director.

In January 2016, we conducted a review of the system's progress after 6 months (July 1, 2015 through December 31, 2015) of implementing its action plans. We created three specific action plan topics and grouped the responses into the appropriate topic area.

Summary of the System's Action Plan

ED Boarding

- Tabulate and track trends in patient flow and wait times on a monthly basis.
- Re-design the UM [6] team structure.
- Designate a Patient Flow Coordinator.
- Designate a location for patient overflow during ED surges.
- Require the Transfer Coordinator to assist with system ED transfers to other VA or non-VA EDs.
- Establish agreement(s) with community hospital(s) to accept transfers for admission.
- Establish a float pool of nurses to assist with ED surges.

Inpatient Flow

- Require UM staff to review data, including bed utilization, to determine which bed types are needed.
- Increase the number of full-time UM employees to a total of 3.0 in April 2015.
- Purchase and install additional equipment on the medical/surgical unit to increase the number of telemetry beds.
- Purchase and utilize POC phones on inpatient units.
- Implement a more robust discharge communication process at the provider level to decrease the inpatient ALOS by 0.6 days.
- Assemble a team of unit nurses, doctors, and social workers to review patients' discharge needs on inpatient units 5 days a week.

RN Staffing Concerns

- Supplement nurse staffing throughout the system with a new float pool of registered nurses.

[6] UM is an admission review screening process used to determine the appropriateness of admission to a specific level of care. Nationally-approved, standardized objective, evidence-based criteria must be used to determine the appropriateness of admission to specific levels of care.

- Utilize VA traveling and agency contract nurses to supplement staffing plans.

ED Boarding

The American College of Emergency Physicians defines an ED-boarded patient as a patient who remains in the ED after they have been admitted to the facility, but have not been transferred to an inpatient unit.[7] The Institute of Medicine in 2006 reported that

> *"…boarding not only compromises the patient's hospital experience, but adds to an already stressful work environment, enhancing the potential for errors, delays in treatment, and diminished quality of care."*[8]

The Joint Commission (JC)[9] requires facilities to recognize that the management of ED boarding is a hospital-wide concern, and to implement system-wide processes that support patient flow elements including admission, assessment and treatment, patient transfer, and discharge.[10] In the interest of patient safety and quality of care, JC requires facilities to set goals regarding boarding times[11] and recommends that patients not be held in the ED for more than 4 hours after a decision to admit is made.[12]

VHA policy states that patients held in the ED for 4 hours or more after admission orders are placed, must be designated as boarders.[13]

ED Patient Flow Metric

VHA policy requires that all VA facilities with an ED or Urgent Care Clinic fully implement and utilize the ED Integration Software (EDIS) tracking program for data entry.[14] The data are automatically transmitted to the VA Corporate Data Warehouse and are displayed in the VHA Emergency Medicine Management Tool (EMMT). The

[7] American College of Emergency Physicians. https://www.acep.org/Clinical---Practice-Management/Definition-of-Boarded-Patient-2147469010/. Accessed April 20, 2016.
[8] National Academies Press, *Hospital-Based Emergency Care: At the Breaking Point*. 2006.
[9] The Joint Commission is an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
[10] JC *Standard LD.04.03.11* (2011).
[11] JC, *Standard PC.01.01.01 EP 6*, "The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department." This element did not affect accreditation status until January 1, 2014.
[12] JC, *The "Patient Flow Standard" and the 4-Hour recommendation*, June 2013. This 4-hour standard for boarding patients is a recommendation, not a requirement, as the JC recognizes that "meeting such a time frame is not, in some cases, within the control of the accredited organization."
[13] VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
[14] VHA Directive 2011-029, *Emergency Department Integration Software (EDIS) For tracking patient activity in VHA Emergency Departments and Urgent Care Clinics*, July 15, 2011. This Directive expired July 31, 2016 and was replaced by VHA Directive 1101.05, Emergency Medicine, September 2, 2016.

EMMT tracks historical data and allows comparison of ED patient flow data across facilities with similar complexity.

At the system's ED, the patient flow process begins with the patient presenting to the ED. The triage nurse evaluates the patient for the acuity of illness to determine if immediate medical attention is necessary. The medical support assistant registers the patient, which triggers the first EDIS entry with a time stamp, thus beginning the LOS metric. Once the patient is seen by the ED provider, orders are written and carried out. When all test results are available, the ED provider reassesses the patient for disposition (discharge or admit) and enters the decision time in EDIS. The ED provider may contact a VA or non-VA facility to initiate a transfer if an inpatient bed or specialist consultation is not available at the system. When the patient leaves the ED (for example, discharged to home, admitted as inpatient, or transferred to a VA or non-VA facility), staff enters the discharge time on EDIS. Thus, EMMT uses EDIS data to calculate certain metrics related to LOS in the ED, utilizing check-in time (when the patient physically enters the ED), time out (when the patient physically leaves the ED) and admission delays (measured from the ED provider's decision-to-admit time to the patient's time out).

Nurse Staffing Metrics

In his May 11 response, the system's Acting Director noted that the system's nurse vacancy rates were usually below the national average; however, the rates were higher than normal with 20 vacant RN positions in Nursing Service. System leaders reported RN vacancies for the ED, ICU, step-down unit, and medical/surgical unit in May 2015 as shown in Table 1.

Table 1. RN Vacancies in May 2015

Unit	RN Vacancies
ED	4
ICU/Step-Down	3
Medical/Surgical Unit	4
Total	**11**

Source: System

To address this issue, system leaders referenced the use of VA traveling and agency contract nurses to supplement staffing, and the creation of a new float pool of 10 RNs to supplement staffing throughout the system and particularly the ED.

Scope and Methodology

In January 2016, we conducted a review of the system's progress after 6 months (July 1, 2015 through December 31, 2015) to assess whether system leaders implemented their action plan to address ongoing issues and if ED-boarded patients' LOS, inpatient flow, and nurse staffing had improved.

We conducted a site visit January 11–14, 2016, and performed three unannounced ED visits during our onsite inspection. We interviewed the Chief of Staff (COS), the Acting Director, who provided the system's February and May 2015 responses to the OIG, the Associate Director for Patient Care Services, the Patient Care Nurse Executive, the ED Medical Director, ED and inpatient physicians and nurses, nurse managers, and other clinical, administrative, and quality management staff with knowledge relevant to the follow-up action plan. We also interviewed the VA National Director of Emergency Medicine.

We randomly selected and reviewed 180 electronic health records (EHR) of 730 ED admitted patients who were boarders from July 1 through December 31, 2015, to determine if the system offered the patients a transfer to a VA or non-VA facility. We reviewed VHA Corporate Data Warehouse data, EMMT data, patient flow data, performance improvement data, and VHA Support Services Center (VSSC) data. We also reviewed VHA and system policies and procedures, email, meeting minutes, and other relevant documents.

During interviews, staff informed us of a patient who was transferred from the system ED and died shortly after arrival to a non-VA facility. We reviewed this patient's EHR, ambulance records, non-VA records, and autopsy report. We reviewed the system's clinical quality assurance documents regarding the patient's care, and relevant policies. We spoke with the Director of Operations of the ambulance company that transported the patient. We reviewed the medical record and medication administration policy from the non-VA facility where the patient died.

VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010, cited in this report, expired June 30, 2015. We considered this policy to be in effect as it has not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[15] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[16] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for

[15] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[16] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[17]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is 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.

[17] Ibid.

Inspection Results

Issue 1: ED Boarding

We determined that system leaders did not fully implement one of seven action items to improve ED-boarded patients' LOS. We found that over 50 percent of ED admitted patients were boarded more than 4 hours. In addition, boarded patients were not offered a transfer of inpatient care to a VA or non-VA facility consistently.

System's Action Plan

Table 2 shows the implementation status for each action item.

Table 2. Implementation Status of Action Plan Items to Improve ED Boarding LOS

Action Item	Implemented	
	Yes	No
A. Tabulate and track trends in patient flow and wait times on a monthly basis.	X	
B. Re-design the UM team structure.	X	
C. Designate a Patient Flow Coordinator.	X	
D. Designate a location for patient overflow during ED surges.	X	
E. Require the Transfer Coordinator to assist with transfers from the system ED to other VA or non-VA EDs.	X	
F. Establish written protocols to identify a process to transfer ED-boarded patients to available VA and non-VA facilities.		X
G. Establish a float pool of nurses to assist with ED surges.	X	

Source: OIG Review of System Action Plan

A. Tabulate and Track Trends in Patient Flow and Wait Times on a Monthly Basis. The system utilized EMMT data to track admit delays of more than 4 hours. System leaders told us that the data were discussed in the daily morning report meeting. The system launched a systems redesign project as part of a National Patient Flow Coordination Collaborative in January 2016. The goal was to track EMMT Service Quality Metric "percent boarded patients >4 hours" data and focus process improvement efforts to reduce the percentage of admitted patients that wait in the ED for >4 hours.

B. Re-Design the UM Team Structure. We found evidence that managers had redesigned the UM team structure.

C. Designate a Patient Flow Coordinator. System Human Resources staff produced an approved position description for a Patient Flow Coordinator; however, during our interviews, staff told us that the position was vacant. We found that the Patient Flow Coordinator was on leave from November 2015 through March 2016. In May 2016, the Patient Flow Coordinator vacated the position, and subsequently, a new person was hired.

D. Designate a Location for Patient Overflow During ED Surges. System leaders originally designated the post-anesthesia care unit as the location for ED overflow patients but on May 6, 2016, the policy was updated and the CLC was designated as the new location for ED overflow.

E. The Transfer Coordinator Will Assist With Transfers From the System ED to Other VA or Non-VA EDs. Transfer coordinators were not initially assigned to the ED to assist with transfers to a VA or non-VA facility. Staff in the ED told us in January 2016 that the ED medical support assistant (MSA) helped with arranging transfers. In October 2016, the system hired a Transfer Coordinator who assisted ED staff with transfers to a VA or non-VA facility.

F. Establish Written Protocols to Identify a Process to Transfer ED-Boarded Patients to Available VA and non-VA Facilities. The COS told us that the system did not have written memoranda of understanding with community hospitals specific to the transfer of ED patients. The system had an informal arrangement with Madera Community Hospital, but the COS stated that many patients needed a higher level of care (specialty services) that Madera Community Hospital did not provide so its ability to accept patients was limited. The COS indicated that the system had a commitment with the academic affiliate, University of California, San Francisco-Fresno Medical Center, to accept patients with an acute ST-elevation myocardial infarction[18] directly into its cardiac catheterization laboratory (regardless of the bed situation). This process consistently worked well according to the COS.

G. Establish a Float Pool of Nurses to Assist With ED Surges. In November 2014, system leaders established a float pool of RNs to assist with ED surges; however, the RNs subsequently filled permanent positions in the inpatient units, which still left staffing shortages in the ED.

[18]ST-elevation myocardial infarction is one type of heart attack and is a development of full thickness cardiac muscle damage resulting from an acute interruption of blood supply to a part of the heart and can be demonstrated by electrocardiography change of ST-segment elevation.

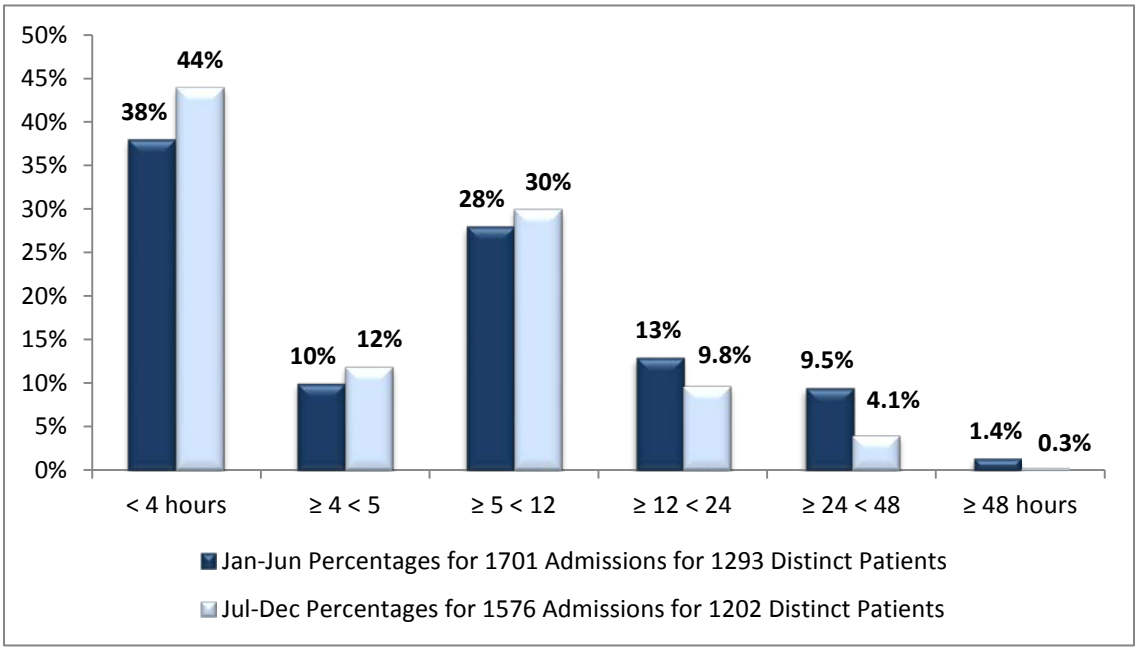
Other Findings

Designated Overflow Location Policy. The ED nurse manager told us that ED patients boarded in the CLC were those that did not require care other than basic activities of daily living, and that ED staff were not assigned to work in the CLC. The system's policy did not identify criteria for ED-boarded patients who could be transferred to the designated overflow location (CLC). Although outside the scope of our review, we do not think it is a sound practice to board ED patients in the CLC without clear criteria and suggest that system managers conduct a review and take appropriate actions.

Offer Transfer for Inpatient Care. System leaders indicated in their May 11, 2015 response that it was routine policy to offer boarded patients a transfer to a VA or non-VA facility for inpatient care. The system's written policies related to ED boarding did not address this. In addition, we made three visits to the ED and talked to boarded patients who told us that they were not offered a transfer for inpatient care. We also reviewed the EHRs of patients boarded in the ED from July 1, 2015, through December 31, 2015, and found that 173 of 180 (96 percent) EHRs did not contain documentation that the patient was offered a transfer to another VA or a non-VA facility.

Boarded Patient LOS. Using EDIS/EMMT data, we compared ED patients' wait times for the 6-month period before the system implemented their action plan (January 1, 2015, through June 30, 2015) to the 6-month period after implementation. (July 1, 2015, through December 31, 2015). We selected 6 intervals ranging from less than (<) 4 hours to greater than or equal (≥) to 48 hours. We identified a 6 percent increase in the number of patients admitted <4 hours after implementation of the action plan. We also found an increase in the number of boarded patients staying ≥4 hours to <12 hours and a decrease in the number of boarded patients staying in the ED ≥12 hours. Although we noted an overall improvement in the boarded patient LOS, 56 percent of the patients were still waiting ≥4 hours as shown in Table 3.

Table 3. ED Wait Times Before and After Action Plan Implementation



Source: Corporate Data Warehouse

Issue 2: Inpatient Flow

We found that the system had fully implemented all six action items to improve inpatient flow.

System's Action Plan

Table 4 shows the implementation status for each action item.

Table 4. Implementation Status of Action Plan Items to Improve Inpatient Flow

Action Item	Implemented	
	Yes	No
A. Require UM staff to review data, including bed utilization, to determine which bed types are needed.	X	
B. Increase full-time UM employees to 3.0 in April 2015.	X	
C. Purchase and install additional equipment on the medical/surgical unit to increase the number of telemetry beds.	X	

Action Item (cont.)	Implemented	
	Yes	No
D. Purchase and utilize POC phones on the inpatient units.	X	
E. Implement a more robust discharge communication process at the provider level to decrease the inpatient ALOS by 0.6 days.	X	
F. Assemble a team of unit nurses, doctors, and social workers to review patients' discharge needs on inpatient units 5 days a week.	X	

Source: OIG review of System Action Plan

A. Require UM Staff to Review Data, Including Bed Utilization, to Determine Which Bed Types are Needed. UM nurses conduct inpatient admission reviews to determine the appropriateness of admissions based on evidence-based criteria. They also track UM data on a monthly basis and report the results to system leaders. VHA policy states that as a key tool in managing daily patient flow activities, UM identifies appropriateness of level of care and services, provides information to assist with decision making related to patient care management and discharge coordination processes, and identifies delays in treatment and services.[19]

B. Increase Full-Time UM Employees to 3.0 in April 2015. The system had three approved full time employees (FTE) on the UM team; however, one FTE had collateral duties. In early 2015, system leaders removed the collateral duties, thus dedicating all three FTEs to UM. On January 11, 2016, one of the positions was vacant; however, the position was filled in March 2016.

C. Purchase and Install Additional Equipment on the Medical/Surgical Unit to Increase the Number of Telemetry Beds. We found that the system purchased and installed mobile telemetry units on the medical/surgical unit, which increased the number of telemetry beds from four to eight.

D. Purchase and Utilize POC Phones on Inpatient Units. The nurses we interviewed validated the use of POC phones in clinical areas. They reported that communication had improved among team members.

E. Implement a More Robust Discharge Communication Process at the Provider Level To Decrease the Inpatient ALOS by 0.6 days. Staff on the inpatient units told us that they held a multidisciplinary meeting (physician, nurse, social worker) at 1:00 p.m. each

[19] VHA Directive 1117, *Utilization Management Program*, July 9, 2014

Monday through Friday to discuss patient care issues, anticipated discharges, and patient discharge needs.

We could not validate a decrease in the inpatient ALOS by 0.6 days as reported in the May 11, 2015 response to the OIG. System leaders were unable to confirm the original source of the data in their May response. They indicated that the data were likely pulled from VA's Inpatient Evaluation Center source,[20] as that was the data system leaders routinely used to monitor and drive flow improvements. We compared third quarter of fiscal year (FY) 2015 to third quarter FY 2016 VA Inpatient Evaluation Center LOS data for acute care. The LOS was 5.31 days and 4.23 days, respectively.

F. Assemble a Team of Unit Nurses, Doctors, and Social Workers to Review Patients' Discharge Needs on Inpatient Units 5 Days a Week. As mentioned in item E, the teams on the inpatient units conducted routine multidisciplinary meetings to discuss discharge needs and anticipated discharges for the next day.

Inpatient Flow Improvements

We concluded that system leaders implemented actions to improve inpatient flow. However, staff told us that inpatient flow was an ongoing challenge due to the number of patients waiting on the acute inpatient unit for community nursing home placement, as well as the limited number of acute inpatient beds to meet the demand for acute care services.

Issue 3: Nurse Staffing Concerns

We found that system leaders had implemented their plan to improve RN staffing in the ED, ICU, step-down, and medical/surgical units.

System's Action Plan To Improve RN Staffing

Table 5 shows the implementation status for each action item.

[20] VA Inpatient Evaluation Center is designed to improve outcomes for patients in the acute hospital setting by measuring and reporting those outcomes, developing new quality metrics, and identifying evidence based practices. Inpatient Evaluation Center analyzes data from each medical center and generates reports comparing risk adjusted mortality, length of stay, and adherence to process measures.

Table 5. Implementation Status of Action Plan Items To Improve RN Staffing

Action Item	Implemented	
	Yes	No
A. Supplement nurse staffing throughout the system with a new float pool of registered nurses.	X	
B. Utilize VA traveling and agency contract nurses to supplement staffing plans.	X	

Source: OIG review of System Action Plan

A. Supplement Nurse Staffing Throughout the System With a new Float Pool of Registered Nurses. As previously mentioned, system leaders established a float pool in November 2014; however, some of the RNs subsequently filled permanent positions in the inpatient units which still left staffing shortages in the ED.

B. Utilize VA Traveling and Agency Contract Nurses To Supplement Staffing Plans. The system used traveling[21] and agency contract nurses to supplement staffing. The system had a contractual agreement with a private nurse staffing company to provide RN services to include medical, surgical, ICU, and ED. The contract was renewed on October 1, 2016, and expired on September 30, 2017.

Nurse Staffing Improvements

We reviewed the system's RN staffing levels for the ED, ICU/step-down unit, and the medical/surgical unit. We found that the number of RN vacancies had decreased as of January 28, 2016, from the previous vacancy numbers indicated in the system's May 11, 2015 response. See Table 6 for the comparison data.

Table 6. RN Vacancies in May 2015 Compared to January 2016

Unit	May 2015	January 2016
ED	4.0	3.0
ICU/Step-Down	3.0	2.0
Medical/Surgical Unit	4.0	0
Total	**11.0**	**5.0**

Source: System's Human Resource Department

[21] A traveling nurse is a nurse who is hired to work in a specific location for a limited amount of time.

Issue 4: Patient Death

During interviews, staff informed us of a patient who was transferred from the system ED to a non-VA facility due to the lack of an available inpatient bed and died shortly after arrival. See Appendix A for background information on atrial fibrillation (AF) and alcohol withdrawal.

The patient was a man in his 60's with a history of alcohol dependence, hypertension, chronic obstructive pulmonary disease (COPD),[22] AF, and heart valve disease, who presented to the ED in 2015 complaining of shortness of breath. The emergency physician (EP) determined that the patient had mild alcohol withdrawal symptoms and a COPD exacerbation. During his ED stay, he developed a rapid, irregular heart rate (AF with rapid ventricular rate (RVR)). The EP ordered a continuous intravenous (IV) medication to slow down the patient's heart rate. According to the system's policy, the ordered medication was reserved for critical care areas[23] and could not be administered to patients on a medical/surgical floor as patients receiving the medication needed to be closely monitored.

Many of the administrative issues discussed earlier in this report manifested in this patient's care. On this particular day, neither the system nor nearby hospitals had an available inpatient bed. The system ED had 10 boarded patients. ED staff found an available inpatient bed at a non-VA facility located 3 hours away. The patient's transfer was delayed by 2.5 hours because a nurse was unavailable to accompany the patient in the ambulance. After the nurse became available, the EP did not reassess the patient for suitability for 3 hours of travel. The ED nurse did not document whether he/she informed the EP about the patient's abnormal vital signs prior to transfer. The patient had a heart rate well above normal for 5 hours while at the ED.

The patient was transported on the maximal infusion rate of the continuous IV medication with a persistent rapid heart rate for 3 hours in the ambulance. The patient became pulseless about 30 minutes prior to arrival at the non-VA facility. He was pronounced dead 90 minutes after arriving at the non-VA facility. The physician at the non-VA facility documented that the patient's immediate cause of death was AF with RVR. The autopsy report indicated that the patient died from sudden cardiac arrest presumably from hypertensive, cardiovascular disease.

The patient had multiple medical problems (COPD, AF, hypertension, heart valve disease) and the prolonged period of a rapid heart rate increased his risk for an adverse outcome. The AF with RVR could have been triggered by alcohol withdrawal and/or COPD exacerbation. The long ED LOS and transport time could have worsened his alcohol withdrawal symptoms. Although the patient had received Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale evaluations and treatments while at

[22] COPD encompasses chronic bronchitis and emphysema and is commonly caused by tobacco use.
[23] Critical care areas are defined as ICU, step down, post anesthesia care unit, ED, gastroenterology lab, and catheter lab.

the ED, the accompanying nurse was not able to repeat the CIWA evaluation during the ambulance ride.[24]

We determined that multiple clinical and administrative factors might have contributed to the patient's death:

Clinical Factors

- The EP did not re-evaluate the patient's response to the continuous IV medication or consider alternative treatment strategies when the medication was not effective in lowering the patient's heart rate.
    - The EP could have kept the patient in the ED and consulted a cardiologist or an intensivist.
    - This patient needed ICU level of care once he was placed on the continuous IV drip. The system policy for the medication required patients on this medication to be admitted to an intensive care unit bed due to the need for continuous cardiopulmonary monitoring.
    - Frequent communication between the ED staff and the Patient Flow Coordinator might have led the staff to re-evaluate whether an ICU bed could have been made available by moving patients with less critical care needs to non-ICU beds.
- The EP did not consider helicopter ambulance transport, which would have shortened the duration of travel.
    - The EP could also have requested a critical care flight nurse from the ambulance company to accompany the patient.

Administrative Factors

- System leaders were not sufficiently aggressive with moving boarded patients out of the ED to appropriate locations for the needed level of care.
    - In situations where the ED held multiple boarded patients, system managers should have actively assisted with bed management and inpatient flow.
    - On this day, the Patient Flow Coordinator was on leave and it was unclear whether anyone was designated as backup.
- System leaders had not identified an ED patient overflow area capable of taking telemetry patients.

[24] The CIWA scale is a measure of withdrawal severity used by the system staff that included a treatment protocol. The CIWA protocol is located in the EHR and the nurse would need to bring the paper version and enough medications for the trip. See Appendix 1 for more details about CIWA.

- Although system leaders had established a nurse float pool, there was no readily available nurse to travel with the patient. The patient might not have waited 2.5 hours for a travel nurse if the system had a robust nurse float pool.

System clinicians performed peer reviews of this patient's care. Subsequently, the VISN Chief Medical Officer obtained a review from a cardiologist, who opined that the care was adequate. An institutional disclosure was not done. An external administrative review to determine whether the system was adequately prepared to safely manage its patient volume may provide specific feedback to assist leadership.

Conclusions

We found that system leaders did not implement 1 of the 15 action plan items related to ED boarding, inpatient flow, and nurse staffing. System leaders did not establish written protocols to identify a process to transfer ED-boarded patients to available VA and non-VA facilities when acute inpatient beds were unavailable. In addition, the system's policy that addressed the designated location for ED patient overflow did not identify criteria for ED-boarded patients who could be transferred to the CLC.

System leaders indicated in their May 11, 2015 response that it was routine policy to offer boarded patients a transfer to a VA or non-VA facility for inpatient care; however, system policies related to ED boarding did not address this. We found that most boarded patients' EHRs did not have documentation that the patients were offered transfers of inpatient care to a VA or non-VA facility.

We determined that the system made some improvements in the overall LOS for boarded patients but improvement is still needed. There was a 6 percent increase in the number of boarded patients' LOS <4 hours. However, 56 percent of boarded patients were still waiting ≥4 hours. We also determined that the boarded patients' LOS ≥12 hours decreased by 10 percent, while the number of boarded patients staying ≥4 hours but <12 hours increased by 4 percent.

System leaders had implemented actions to improve inpatient flow. We found that the LOS had decreased by 1.08 days from 3rd quarter FY 2015 to 3rd quarter FY 2016. Inpatient flow remained a challenge for system leaders due, in part, to the LOS for patients waiting on the acute care unit for community nursing home placement, as well as the limited number of acute inpatient beds to meet the demand for acute care. Although we found that system leaders were addressing these ongoing issues, more work is needed.

We reviewed the system's RN staffing levels for the ED and the intensive care, step-down, and medical/surgical units. The total number of RN vacancies had decreased to 5 as of January 28, 2016, from the previous 11 vacancies indicated in the system's May 11, 2015 response to the OIG.

In the course of our review, we identified a patient whose adverse outcome illustrated many of the challenges associated with boarded patients who need to be transferred due to the unavailability of inpatient beds. This patient presented to the ED on a day when the system and the local hospitals had no available inpatient beds. In addition, the patient experienced delays in transfer due to the unavailability of a nurse to accompany him and did not receive a reassessment to determine suitability for transfer. The patient died after a prolonged transport on the maximal dose of a medication that is generally administered in a setting where intensive monitoring and resources are available.

System clinicians performed peer reviews of this patient's care. Subsequently, the VISN Chief Medical Officer obtained a review from a cardiologist, who opined that the care was adequate. An institutional disclosure was not done. An external administrative review to determine whether the system was adequately prepared to safely manage its patient volume may provide specific feedback to assist leadership.

Because the system failed to adequately correct ED patient flow and nurse staffing after becoming aware of issues in these areas, we have directed recommendations associated with this report to the VISN.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director ensure that System leaders establish written protocols to identify a process to transfer Emergency Department boarded patients to available VA and non-VA facilities when acute inpatient beds are unavailable.

2. We recommended that the Veterans Integrated Service Network Director ensure that the policy that designates the location for Emergency Department patient overflow includes criteria for boarded patients who can be placed in the community living center.

3. We recommended that the Veterans Integrated Service Network Director ensure that a policy is developed and implemented to ensure that Emergency Department staff offer boarded patients transfer to a VA or non-VA facility for inpatient care and that Emergency Department staff document the offers and managers monitor compliance.

4. We recommended that the Veterans Integrated Service Network Director ensure that managers continue to strengthen processes to improve boarded patients' length of stay in the Emergency Department.

5. We recommended that the Veterans Integrated Service Network Director ensure that Emergency Department providers reassess patients prior to transfer to confirm that patients are stabilized and suitable for transfer to the receiving unit.

6. We recommended that the Veterans Integrated Service Network Director implement applicable recommendations from previous patient event-related reviews and monitor compliance.

7. We recommended that the Veterans Integrated Service Network Director consult with the Office of Chief Counsel regarding whether an institutional disclosure might be appropriate.

8. We recommended that the Veterans Integrated Service Network Director consider requesting an external administrative review to determine whether the system was adequately prepared to safely manage its patient volume.

Appendix A

Overview of Atrial Fibrillation and Alcohol Withdrawal

Atrial Fibrillation

AF is a common disease causing an irregular heart rhythm. Occasionally, patients with AF may have an RVR (a heart rate greater than 100 beats per minute). Consequentially, they may have poor circulation (decreased blood output from the heart due to less filling time) and an increased risk for blood clots, stroke, and death. Symptoms of AF vary but include shortness of breath, palpitations, fatigue, and general malaise.

Acute treatments of patients who present to the hospital in AF with RVR depend on the severity of their vital signs and symptoms. Patients who show poor circulation, typically manifested as low blood pressure, will need electrical therapy to convert AF back to a normal rhythm. Patients, who are stable, without signs of poor circulation, may be given oral or IV medications to slow their heart rate. The optimal heart rate goal has not been determined but some research trials used a resting rate of ≤80 and an exertional rate of ≤110 as thresholds.

Alcohol Withdrawal

Alcohol dependence is a common disease in the U.S. Alcohol is a central nervous system depressant. Abrupt cessation of alcohol for chronic users disinhibits this depression and results in over-activity of the central nervous system. This pathophysiology manifests with a variety of symptoms, including rapid heart rate, hypertension, tremors, seizures, and hallucinations. The timing of symptom onset correlates with the time since the patient's last drink. Patients require frequent re-evaluation of the severity of their withdrawal symptoms to guide treatment, especially because the longer the elapsed time since their last drink, the more severe the withdrawal symptoms.

The CIWA scale was a measure of withdrawal severity used by system staff. Symptoms evaluated include nausea/vomiting, tremor, sweats, anxiety, tactile, auditory and visual disturbances, headaches, agitation, and orientation/clouding of sensorium. The scale score ranged from 0 to 67. Benzodiazepines, such as lorazepam, are the main stay of treatment for alcohol withdrawal symptoms. The CIWA scale used by the system had specific order sets for the dosing of lorazepam based on a patient's symptoms.

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 4, 2017

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Administrative and Clinical Concerns, Central California VA Health Care System, Fresno, California

To: Director, San Diego Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the draft report. I concur with the information provided and the corrective action plan that has been put into place by the Facility.

2. Should you have any questions please contact the Deputy Quality Manager for V21 at (707) 562-8350.

Sheila M. Cullen
Director, Network 21

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 Veterans Integrated Service Network Director ensure that Systems leaders establish written protocols to identify a process to transfer Emergency Department boarded patients to available VA and non-VA facilities when acute inpatient beds are unavailable.

Concur

Target date for completion: December 31, 2017

Facility response: Written policy will be updated to identify steps in the process of acquiring VA and non-VA beds for Emergency Department boarded patients when acute inpatient beds are unavailable.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure that the policy that designates the location for Emergency Department patient overflow includes criteria for boarded patients who can be placed in the community living center.

Concur

Target date for completion: December 31, 2017

Facility response: Written policy will be revised to designate original overflow unit location (i.e. Post-Anesthesia Care Unit instead of Community Living Center) and criteria for boarded patients who can be placed there.

Recommendation 3. We recommended that the Veterans Integrated Service Network Director ensure that a policy is developed and implemented to ensure that Emergency Department staff offer boarded patients a transfer to a VA or non-VA facility for inpatient care and that Emergency Department staff document the offers and managers monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: Will standardize documentation process for staff communication on transferring patients; will educate nursing staff accordingly. Process will be monitored until compliance can be achieved at 90% for three consecutive months.

Recommendation 4. We recommended that the Veterans Integrated Service Network Director ensure that managers continue to strengthen processes to improve boarded patients' length of stay in the Emergency Department.

Concur

Target date for completion: Completed

Facility response: Daily multi-disciplinary discharge huddle with executive team initiated; clinical navigators added to inpatient clinical teams; daily Nursing Morning Report expanded to include EMS, Pharmacy, and Logistics; weekly multi-disciplinary huddle with Geriatrics and Extended Care Service initiated; Veterans Choice agreements with three local long-term care centers and short-term rehabilitation hospital in place; weekly analysis of leading data indicators related to patient flow initiated.

Recommendation 5. We recommended that the Veterans Integrated Service Network Director ensure that Emergency Department providers reassess patients prior to transfer to confirm that patients are stabilized and suitable for transfer to the receiving unit.

Concur

Target date for completion: November 30, 2017

Facility response: ED providers will assess and document concurrence in a progress note prior to actual transfer, to verify patient is stable and suitable for said transfer. Process will be monitored until compliance can be achieved at 90% for three consecutive months.

Recommendation 6. We recommended that the Veterans Integrated Service Network Director implement applicable recommendations from previous patient event-related reviews.

Concur

Target date for completion: Completed

Facility response: The facility represented that all recommendations from previous patient event-related reviews have been addressed.

Recommendation 7. We recommended that the Veterans Integrated Service Network Director consult with the Office of Chief Counsel regarding whether an institutional disclosure might be appropriate.

Concur

Target date for completion: Completed

Facility response: General Counsel consulted. Institutional Disclosure not warranted.

Recommendation 8. We recommended that the Veterans Integrated Service Network Director consider requesting an external administrative review to determine whether the system was adequately prepared to safely manage its patient volume.

Concur

Target date for completion: Completed

Facility response: Telephone consultation in March 2017 with Central Office leadership regarding patient flow determined site visit was not necessary. The facility provides monthly report updates to the Assistant Deputy Under Secretary for Health Clinical Operations, the Assistant Deputy Under Secretary for Quality Safety and Value, and the Deputy Under Secretary for Health Operations Management. Ongoing VORP (VISN Operational Review Program) reviews are routinely conducted by VISN staff and leadership.

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: August 3, 2017

From: Director, Central California VA Health Care System (570/00)

Subj: Healthcare Inspection—Administrative and Clinical Concerns, Central California VA Health Care System, Fresno, California

To: Director, Sierra Pacific Network (10N21)

1. I appreciate the opportunity to provide our input to the facility follow-up review of our health care system which took place during January 2016.

2. I concur with all the findings and suggested improvement actions.

3. On behalf of our health care system and the Veterans we serve, I would like to thank the OIG review team for their hard work and dedication. We found the team members to be very helpful throughout the entire process.

4. We appreciate the important feedback we received from this review and will use the information to further strengthen our administrative and clinical programs.

Sincerely,

Stephen R. Bauman
Director

Appendix D

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 E

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