Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00469-122

Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire

April 6, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Table of Contents

Executive Summary

Introduction

During the week of January 25–29, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Manchester VA Medical Center (the medical center), Manchester, NH. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 126 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

The CAP review covered seven operational activities and one follow-up review area from the previous CAP review. We identified the following organizational strength:

- Community Living Center (CLC) Culture Change

We made recommendations in three of the activities reviewed and in the follow-up review area; two recommendations were repeat recommendations from the prior CAP report. For these activities and the follow-up review area, the medical center needed to:

- Develop a process to address disclosure of adverse events and ensure that senior managers receive an annual written report regarding disclosures.
- Ensure that supervisors implement appropriate actions for all Level 2 and Level 3 peer reviews.
- Ensure that the Peer Review Committee (PRC) completes peer reviews within 120 days or requests an extension from the medical center's Director.
- Fully implement professional practice evaluations and ensure that Professional Standards Board (PSB) meeting minutes reflect discussions regarding performance data.
- Ensure that patients identified as being at high risk for suicide and/or their families receive copies of suicide prevention safety plans.
- Review Computerized Patient Record System (CPRS) business rules quarterly to assess compliance with Veterans Health Administration (VHA) requirements.

The medical center complied with selected standards in the following four activities:

- Coordination of Care
- Environment of Care (EOC)
- Medication Management
- Reusable Medical Equipment (RME)

This report was prepared under the direction of Jeanne Martin, PharmD, Associate Director, Boston Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 12–16, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is a Level III facility located in Manchester, NH, that provides a broad range of outpatient health care services and inpatient CLC services. Outpatient care is also provided at four community based outpatient clinics in Conway, Portsmouth, Somersworth, and Tilton, NH. The medical center is part of VISN 1 and serves a veteran population of about 106,300 in the New Hampshire counties of Belknap, Carroll, Hillsborough, Merrimack, Rockingham, and Strafford.

Programs. The medical center provides primary and secondary care services in medicine, mental health, surgery, extended care, and ambulatory care. It has 41 CLC beds.

Affiliations and Research. The medical center is affiliated with the New England College of Optometry and provides training for one resident. It also provides training for radiology, medical, and optometry students and for students in other disciplines, including nursing, physical therapy, occupational therapy, pharmacy, physician assistant programs, and social work. In fiscal year (FY) 2009, the medical center's research program had 12 projects and a budget of $522,900. An important area of research was post-traumatic stress disorder.

Resources. In FY 2009, medical care expenditures totaled more than $118 million. The FY 2010 medical care budget is over $106 million. FY 2009 staffing was 632 full-time employee equivalents (FTE), including 36 physician and 129 nursing FTE.

Workload. In FY 2009, the medical center treated 21,897 unique patients and provided 12,780 inpatient days in the CLC. The inpatient care workload totaled 154 discharges, and the average daily census of CLC patients was 35. Outpatient workload totaled 215,277 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

In performing the review, we inspected work areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area:

- Coordination of Care
- CPRS Business Rules
- EOC
- Medication Management
- Physician Credentialing and Privileging (C&P)
- QM
- RME
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2008, FY 2009, and FY 2010 through January 25, 2010, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire,* Report No. 07-03100-63, January 23, 2008). We had two repeat findings from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 126 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Community Living Center Culture Change

The medical center has made significant strides in the implementation of culture change in its CLC. In quarter 1 of FY 2008, the medical center scored 108 points out of a possible 360 points on a VISN tool that assesses elements of culture change, such as care practices, physical environment, and family and community involvement. In quarter 1 of FY 2010, the score had risen to 251 out of a possible 360 points—a 70 percent increase.

Successful implementation is linked to leadership involvement, staff education on the concepts, maintenance of an ongoing project list, and interdisciplinary involvement. Staff involvement was strengthened by including culture change criteria as part of each employee's performance evaluation. Emphasis was initially placed on environmental artifacts, and these concrete changes established constant visual reminders of culture change goals for patient-centered and homelike care.

Voluntary Service has been successful in engaging the community. One community based corporation provided three teams, totaling more than 100 volunteers, to help transform the environment in the CLC. Their efforts included painting, gardening, and improving outside areas.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers, patient safety employees, and the QM coordinator.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following areas that needed improvement.

Adverse Event Disclosure. VHA policy requires the medical center to have a process in place to disclose to patients serious adverse events that have occurred during the course of their care.[1] The Joint Commission (JC) requires that senior managers receive a written report regarding the disclosure of adverse events to patients at least once a year. We did not find a process in place for providers to address adverse events that may require disclosure. Additionally, we did not find that senior managers received written reports of disclosure.

Peer Review. VHA policy requires the supervisor of an individual assigned a Level 2 or Level 3 peer review to ensure that appropriate non-disciplinary, non-punitive action is implemented.[2] Furthermore, the supervisor must submit written notification of the completed action to the PRC. We did not find evidence that actions had been taken when appropriate.

Additionally, VHA and medical center policies on peer review require that the PRC complete final reviews of cases within 120 days from the date it was determined that a peer review was needed. If the review cannot be completed in that time, the PRC should request approval for an extension from the medical center's Director. We did not find data to support that the PRC completed peer reviews within 120 days or that extensions had been requested. This was a repeat finding from our previous CAP review.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that managers develop a process to address adverse events that may require disclosure and that senior managers receive a written report regarding the disclosure of adverse events at least annually.

[1] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[2] VHA Directive 2008-004, *Peer Review for Quality Management,* January 28, 2008.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires supervisors to implement appropriate actions for all Level 2 and Level 3 peer reviews.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to complete peer reviews within 120 days or request an extension from the medical center's Director.

The VISN and the Medical Center Directors agreed with the findings and recommendations. The risk manager will provide training on adverse event disclosure, develop a process to track disclosure, and submit a written annual report to the medical center's Director. Supervisors of individuals assigned a Level 2 or Level 3 peer review will submit written notification to the PRC when appropriate actions have been implemented. The PRC will track all peer reviews to completion, and the risk manager will track open actions and report status monthly to the PRC. PRC minutes have been modified, and the PRC will request any extensions from the medical center's Director in sufficient time to allow for the approval prior to the 120-day limit. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected elements required by VHA policy in C&P files and physician profiles.[3] We also reviewed PSB meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles. All 10 physicians were either appointed to the medical staff or reprivileged within the past 12 months. We found that licenses were current and that primary source verification had been obtained.[4] However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA policy requires specific competency criteria for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians.

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[4] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

Although we found OPPEs for the nine reprivileged physicians, we did not find an FPPE for the one newly hired physician. In addition, for the nine reprivileged physicians, PSB meeting minutes did not reflect detailed discussions of the physicians' performance data prior to reprivileging.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires professional practice evaluations to be fully implemented and PSB meeting minutes to reflect discussions regarding performance data.

The VISN and the Medical Center Directors agreed with the findings and recommendation. FPPE formats are under review. Once finalized, they will be used to evaluate new providers and existing providers who request new privileges. PSB meetings minutes will be amended to include discussions regarding performance data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[5] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of 10 patients assessed to be at high risk for suicide and identified the following area that needed improvement.

[5] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Safety Plans. VHA requires patients at high risk for suicide to receive a copy of the written safety plan.[6] In 3 (30 percent) of the 10 records reviewed, clinicians did not document that patients and/or their families were provided copies of the safety plans.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to document that patients at high risk for suicide and/or their families are provided with copies of suicide prevention safety plans, as required by VHA.

The VISN and Medical Center Directors agreed with the finding and recommendation. All patients have received copies of their safety plans, and their medical records have been updated to reflect this. The suicide prevention coordinator will monitor compliance with VHA policy on patient safety plans and will conduct monthly reviews to assure that written safety plans meet all requirements and that copies have been provided to patients and/or their families. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Computerized Patient Record System Business Rules

In our previous CAP report, we recommended that the medical center require managers to review CPRS business rules regularly to assess compliance with VHA requirements. Facility managers responded that the Chief of Health Information Management Service (HIMS) and/or the Computer Applications Coordinator would review CPRS business rules quarterly and report to the Medical Records Committee and the Quality Executive Board (QEB). However, we found the following.

Business Rule Review and Reporting. Managers could not provide supporting documentation that they reviewed CPRS business rules quarterly (repeat finding from our previous CAP review) or that results of reviews were reported to the Medical Records Committee and the QEB.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires review of CPRS business rules quarterly to assess compliance with VHA requirements.

[6] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

The VISN and Medical Center Directors agreed with the finding and recommendation. The Chief of HIMS will conduct quarterly reviews of the CPRS Business Rules and will report findings to the medical center's Administrative Executive Board (AEB). The AEB has added this as a standing agenda item to monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program.[7] We determined that the medical center had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the medical center's urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policies and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions.[8] We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements and that follow-up appointments were scheduled appropriately. We made no recommendations.

[7] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[8] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

Environment of Care

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

We inspected the CLC, the urgent care clinic, the primary care area, the pharmacy, the dental clinic, and specialty clinic areas. The medical center maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments complied with VHA standards. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The medical center had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[9] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Clinical personnel properly documented influenza vaccinations for CLC residents.

In addition, although the pharmacy is closed from 6:00 p.m. to 8:00 a.m. daily, we found that the medical center provided a qualified pharmacist to answer questions during those hours and had an adequate process to review provider orders. We made no recommendations.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The medical center's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA,

[9] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

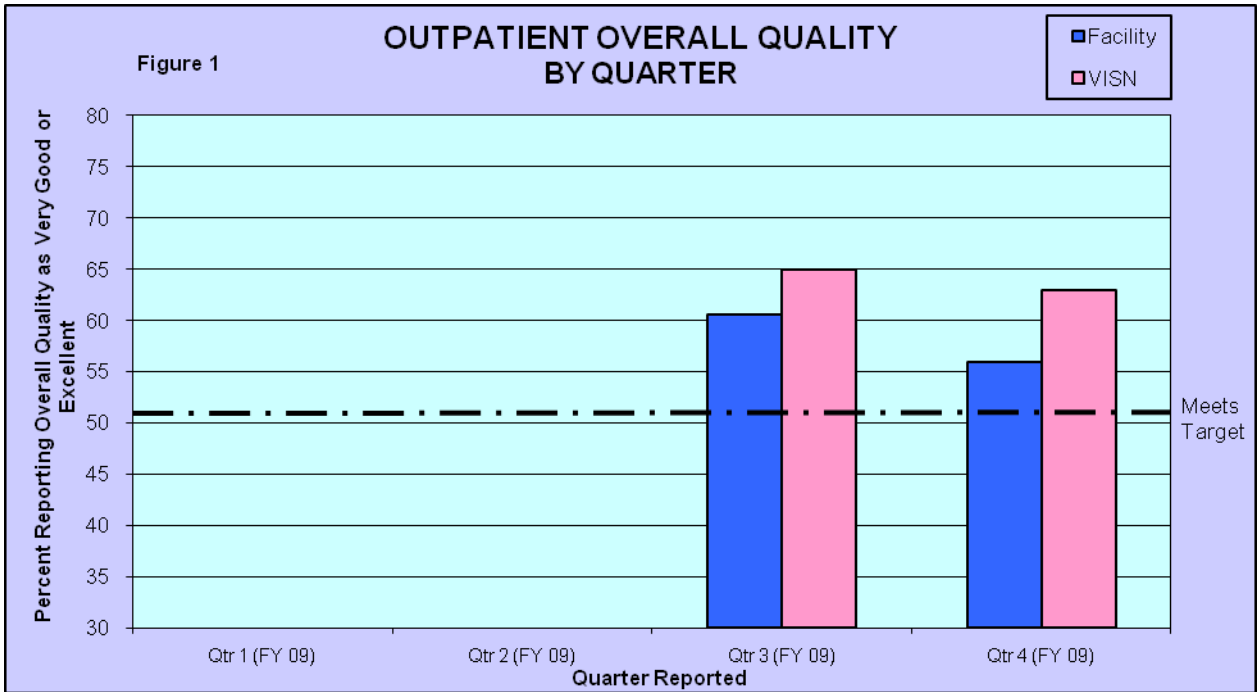
We inspected the operating room and SPD reprocessing areas. We determined that the medical center had appropriate policies and procedures and consistently monitored compliance with established guidelines. In addition, the medical center had a process in place to track RME should a sterilization failure occur.

For eight pieces of RME, we reviewed the standard operating procedures (SOPs) for reprocessing. In general, we found that SOPs were current and consistent with the manufacturers' instructions. Also, employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies and training were current and consistently documented. We made no recommendations.

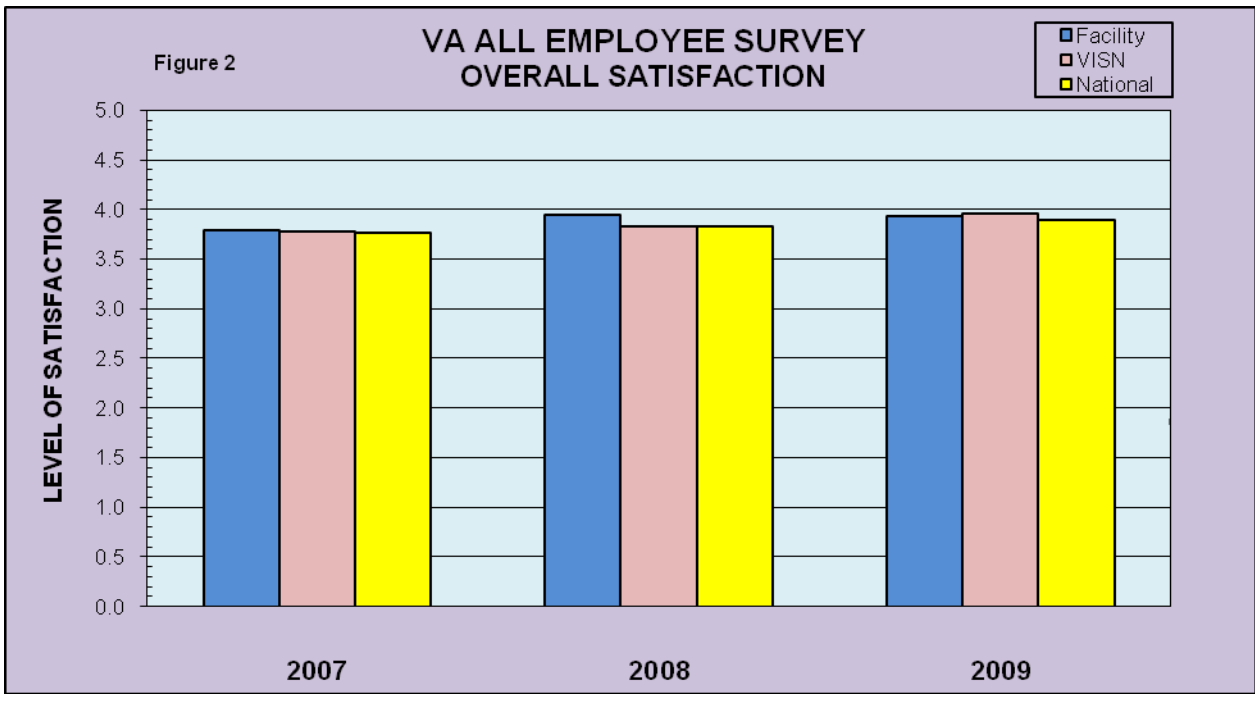
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[10] The target score is noted on the graph. The medical center had no acute care beds, so inpatient scores were not applicable.

[10] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 2 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 12, 2010

From: VISN Director

Subject: **Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire**

To: Associate Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Service (VHA CO 10B5 Staff)

I concur with the findings and recommendations contained in this review. Responses to the recommendations are attached.

For any questions, please contact Allan Shirks, MD, VISN 1 QMO, 781 687 4850.

(original signed by:)
Michael Mayo-Smith, MD, MPH
Network Director

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 12, 2010

From: Medical Center Director

Subject: **Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire**

To: Associate Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Service (10B5)

I concur with the findings/recommendations presented in this Combined Assessment Program Review of the Manchester VA Medical Center. Actions taken as a result of these findings are attached.

(original signed by:)
Marc F. Levenson, MD, MBA
Medical Center Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that managers develop a process to address adverse events that may require disclosure and that senior managers receive a written report regarding the disclosure of adverse events at least annually.

Concur

The risk manager shall develop and provide training for all providers on their responsibility to and process for disclosure of adverse events. In addition the risk manager shall develop a process for tracking disclosure of adverse events. The risk manager will submit a written annual report to the Medical Center Director through the Executive Committee of Medical Staff (ECOMS) summarizing the number of adverse events that resulted in disclosure. The estimated completion date to close out this recommendation is 6/1/2010.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires supervisors to implement appropriate actions for all Level 2 and Level 3 peer reviews.

Concur

The supervisor of an individual assigned a Level 2 or Level 3 review shall be responsible to submit written notification to the PRC that appropriate actions have been implemented. The PRC will be responsible for tracking all peer reviews to completion including the documentation that appropriate actions have been implemented. The risk manager will track open actions using an excel spreadsheet and report status monthly to the PRC who will take action as necessary. The estimated completion date to close out this recommendation is 5/1/2010.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to complete peer reviews within 120 days or request an extension from the medical center's Director.

Concur

Peer reviews are now tracked in an Access database. In addition, for tracking purposes, the PRC minutes have been modified to include the date that the peer review was initiated so that it is more clearly evident when Peer Reviews are approaching the 120 day limit. The PRC will submit a memorandum requesting an extension to the Director in sufficient time to allow for the approval prior to the 120 day limit. The estimated completion date to close out this recommendation is 5/1/2010.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires professional practice evaluations to be fully implemented and PSB meeting minutes to reflect discussions regarding performance data.

Concur

FPPE formats are under review by the Medical Staff and will be finalized by March 30, 2010. This format will be used to evaluate new providers and when existing providers request new privileges. The PSB meetings minutes will be amended to reflect discussions regarding performance data to include the following statement:

The following documents and OPPE or FPPE information in the provider's profile were reviewed and were acceptable except as noted in these minutes: medical education, training, continuing medical education (CME) credits, licenses, certifications, registrations, drug enforcement agency (DEA) registrations, information from the national practitioner data bank and/or federation of state medical boards, and current limits of professional liability, if required.

PSB minutes will include any exceptions to this statement in the narrative of each individual provider. The estimated completion date to close out this recommendation is 5/1/2010.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to document that patients at high risk for suicide and/or their families are provided with copies of suicide prevention safety plans, as required by VHA.

Concur

All patients have received copies of their safety plans and their medical records updated to reflect this information. The suicide prevention coordinator shall be responsible for monitoring compliance with VA policy on patient safety plans. He/she shall conduct monthly reviews of all patients who have been identified as being at high risk for suicide (flagged) during the month. The review, at a minimum shall assure that written safety plans meet all VA requirements including but not limited to evidence that a copy of the plan was given to the patient and/or family. In

cases where VA requirements were not met specific corrective action plans shall be developed and implemented. These actions plans shall be included in suicide prevention coordinators monthly review. The suicide prevention coordinator shall report his/her findings monthly to the Mental Health Service Line Manager and quarterly to medical center's QEB who will take action as needed. The estimated completion date to close out this recommendation is 6/1/2010.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires review of CPRS business rules quarterly to assess compliance with VHA requirements.

Concur

The Chief of HIMS will conduct quarterly reviews of the CPRS Business Rules and will report findings to the Medical Center's Administrative Executive Board (AEB). The Medical Center Associate Director Chairs the AEB and has placed this as a standing agenda item for the committee to monitor compliance. The estimated completion date to close out this recommendation is 4/1/2010.

OIG Contact and Staff Acknowledgments

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