Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Out-of-Operating Room Airway Management in Veterans Health Administration Medical Centers

Report No. 08-01130-173

July 29, 2008

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The VA Office of Inspector General reviewed Veterans Health Administration (VHA) medical centers to assess compliance with VHA Directive 2005-031, *Out-of-Operating Room Airway Management*, dated August 8, 2005. This subject is important since not all facilities have 24-hour anesthesia coverage; therefore, other clinical staff must be competent in airway management. In addition, VHA recognizes that direct observation of care provided to actual patients is required. The directive addresses appropriate competencies of practitioners who perform urgent and emergent airway management outside of VHA operating rooms and the use of devices to confirm successful tube placement.

We requested specific documentation regarding out-of-operating room airway management from all medical centers with authorized inpatient beds. We reviewed each local policy's compliance with the VHA Directive, discrepancies between local policy and local practice, and compliance with required provider-specific data analysis and facility committee oversight. We also identified best practices.

Despite the fact that the National Center for Patient Safety provided all facilities a sample policy that met Directive requirements, facilities deleted elements or made changes that altered the intent of the Directive as developed locally. When considering compliance with all six required policy elements, 71 of 120 facilities (59 percent) included all six elements. The balance (49 facilities, or 41 percent) included some but not all required elements. There were only 17 of 120 facilities (14 percent) that captured provider-specific competency data for all providers performing airway management; and only 6 of 120 facilities (5 percent) documented committee oversight of aggregate and provider-specific data. This is necessary, since without provider-specific data and oversight, medical centers would be unable to verify provider competency to perform certain procedures. Only three facilities complied with all requirements of the Directive that we reviewed.

We identified areas to improve the out-of-operating room airway management program and patient safety. We recommended that VHA require facilities to apply for a waiver from the Directive if they do not perform out-of-operating room airway management; maintain policies that comply with all elements of VHA Directive 2005-031; and collect provider-specific and aggregate data for airway management and discuss results at their designated oversight committee.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health (10)

SUBJECT: Healthcare Inspection – Out-of-Operating Room Airway Management in Veterans Health Administration Medical Centers

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection of selected Veterans Health Administration (VHA) medical centers to assess compliance with VHA Directive 2005-031, *Out-of-Operating Room Airway Management*, dated August 8, 2005. This Directive addresses appropriate competencies of practitioners who perform urgent and emergent airway management outside of VHA facility operating rooms (ORs), and the use of devices[1] to confirm successful endotracheal tube[2] placement.

Background

Recent OIG reports[3] and a number of findings in recent Combined Assessment Program (CAP) reports address deficiencies in the area of provider privileging, specifically whether VHA appropriately verifies the current competence of providers to perform certain procedures. Clinical competency cannot be assumed simply because training has been provided. Providers who have been trained in Advanced Cardiac Life Support (ACLS) are not necessarily competent to perform airway management, even though it is part of the training. VHA recognizes that in order to ensure competency, direct observation of care provided to actual patients is required.

Airway management is the process of ensuring a patent pathway to the lungs in order to maintain adequate oxygenation. Generally, this process occurs in the OR prior to induction of an anesthetic agent that paralyzes a patient's ability to maintain normal

[1] Devices such as carbon dioxide (CO_2) monitors or esophageal detection devices.
[2] The flexible plastic tube in the mouth and then down into the trachea (the airway); the purpose is to ventilate the lungs.
[3] *Healthcare Inspection – Quality of Care Issues VA Medical Center, Marion, Illinois,* No. 07-03386-65, issued January 28, 2008.
Healthcare Inspection – Quality of Care and Patient Safety Issues, Martinsburg VA Medical Center, Martinsburg West Virginia, No. 07-02191-147, issued June 18, 2007.

breathing. Anesthesia staff are highly trained and experienced to provide this service, and do so on a daily basis. The requirement for emergency airway management arises outside of the OR when patients experience respiratory distress. Because not all medical facilities have 24-hour anesthesia coverage, other clinical staff must be competent in airway management. Risk for adverse outcomes increases when staff are not well trained or competent to perform emergency airway support. A major challenge is the proper placement of an endotracheal tube. This tube, which is inserted through the mouth or nose into the trachea, is the most commonly used method to maintain an artificial airway. If inserted incorrectly, the patient will not receive proper oxygenation, which could result in brain damage or death. Emergency intubations should be performed by clinical staff with demonstrated experience and skill.

In the 1990's, the American Society of Anesthesiologists (ASA) and the American Association of Nurse Anesthetists separately initiated reviews of closed anesthesia malpractice claims to identify causes of poor patient outcomes and identify potential corrective actions to reduce adverse events.[4] Data from these reviews indicated that respiratory events accounted for the majority of all claims filed and for 85 percent of claims for death and brain damage. The most common events were due to inadequate or difficult ventilation and esophageal versus endotracheal intubations. The reviewers were unable to determine the causes of inadequate ventilation but in the cases of esophageal intubations, providers relied on auscultation[5] to verify placement of the tube.[6] As a result of these reviews, use of inexpensive and effective devices to confirm endotracheal tube placement are supported by the American College of Emergency Physicians, ASA, the National Association of Emergency Medical Service Physicians, and the American Heart Association.

In 2002, the National Center for Patient Safety (NCPS) conducted a survey of VHA facilities that confirmed the requirement of emergency airway management outside the OR.[7] Results of this survey indicated an estimated 11,007 cases a year of non-OR intubations in VHA medical facilities. Twelve percent of these were unusually difficult. According to the survey, most facilities reported multiple disciplines provided airway management, including staff physicians, residents, and respiratory therapists. Only 45 percent of facilities reported that anesthesia staff was available after regular/day tours of duty. Additionally, 30 percent reported using no adjunctive devices to confirm proper tube placement.

[4] Caplan, R. A., Posner, K. L., Ward, R. J., and Cheney, F. W. (1990, May). Adverse respiratory events in anesthesia: a closed claims analysis. *Anesthesiology.* 72 (5), 828-833.
[5] Auscultation is the technical term for listening to the internal sounds of the body, usually using a stethoscope; the word is based on the Latin verb *auscultare* "to listen."
[6] MacRae, M. G. (2007, August). Closed claims studies in anesthesia: a literature review and implications for practice. *AANA J.* 75 (4), 267-275.
[7] Stalhandske, E. J., Bishop, M. J., and Bagian, J. P. The Department of Veterans Affairs emergency airway management initiative. Unpublished manuscript.

These findings led to the development of VHA Directive 2005-031, mandating each inpatient facility develop a written policy by December 1, 2005, defining the:

- Practice settings and circumstances that allow endotracheal intubations outside the OR and the designated clinical staff who have these duties.
- Process for confirming competence of those who provide out-of-operating room airway management.
- Device used to confirm tube placement.
- Process for collection and comparison of provider specific data on airway management, with periodic review of both aggregate and provider specific data by a designated committee.

If inpatient facilities use community paramedics to respond to emergencies, then they must submit a waiver request to the Office of Patient Care Services, VA Central Office. Directors of facilities that only provide outpatient care need to ensure that the standard for providing airway management is through community assistance, and no waiver is required. However, if they perform emergency airway management, a policy to address competency of staff performing those procedures should be consistent with the Directive.

Scope and Methodology

Our inspection assessed VHA medical facility compliance with selected elements of Directive 2005-031 that related to provider competency. The review was limited to inpatient facilities. We evaluated VHA required policy and procedure elements, reviewed medical facility processes and documentation of provider competency, and identified best practices.

On February 27, 2008, we electronically submitted a request for documentation pertaining to out-of-operating room airway management to medical center directors of VHA facilities with authorized inpatient beds. Their responses were required by March 21, 2008. Specifically, we requested that the medical facilities provide us the following information from fiscal year (FY) 2006, FY 2007, and FY 2008 through February 28, 2008: (1) facility policy addressing out-of-operating room airway management; (2) list of providers permitted to provide airway management outside the OR and their occupation category; (3) any provider specific quality data concerning airway management for all individuals listed; and (4) minutes of the designated oversight body that reviews aggregate and/or provider specific data regarding airway management.

We requested information from medical center directors of the 131 facilities that we identified as having inpatient beds. Four did not respond and four had received waivers. (See Appendix B, pages 14–17, for facility list). We analyzed and aggregated materials received from the remaining 123 facilities to identify findings in this report.

Our inspection covered the following areas:

- Implementation of out-of-operating room airway management policy by December 1, 2005, that includes requirements for the following six elements:
    - (1) A statement that assessed the number and type of clinical staff whose expected duties include endotracheal intubation and airway management in a non-OR setting.
    - (2) Process for confirming provider competence.
    - (3) Documentation of procedural skills including successful endotracheal intubation of a patient and successful ventilation of an unconscious patient using a bag and mask and either an oral or nasopharyngeal airway.
    - (4) Use of a device to confirm tube placement along with auscultation.
    - (5) Provider-specific data analysis, compared against aggregate data for those privileged to perform airway management.
    - (6) Designated committee periodic review of data.
- Evaluation that providers permitted by the facilities to provide airway management matches policy statement describing occupations of clinical staff with these duties.
- Presence or absence of provider-specific data for all individuals listed by the facility.
- Evaluation that minutes from designated body reflect review of provider-specific data compared to aggregate data regarding out-of-operating room airway management.
- Identification of best practices.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

We noted deficiencies in compliance with Directive 2005-031. Our inspection demonstrated that less than 3 percent of VHA facilities complied with all the selected requirements that we reviewed. We evaluated compliance with required facility policy elements, provider specific and aggregate data, and committee oversight. Specific findings are discussed in the remainder of this report.

Issue 1: Facility Policy Review

The first part of our review related to specific facility policy components. VHA published Directive 2005-031 on August 8, 2005. Each inpatient facility was required to have a written policy in effect by December 1, 2005, and NCPS provided an example of a facility-level policy that met Directive requirements on their website.

We received electronic responses from 127 facilities with inpatient beds. Five were on the waiver list, but one provided a policy and had providers performing out-of-operating room airway management, so we included them in the data analysis. The other four were not included in the data analysis because they had waivers and submitted policies that confirmed their practice of calling 911 for emergency response. The final denominator for policy review was 123 facilities.

Policy Implementation

Of the 123 facilities remaining, 122 submitted a local policy. Two facility policies stated that they called 911 for all emergencies, but they had not requested a waiver. Four policies were still in draft format and not formally approved at the time of our review. Forty-nine of the 122 policies (40 percent) complied with the December 1, 2005, deadline.

Some facilities were confused regarding the "inpatient facility" designation in the Directive. The one facility that did not submit a policy informed us they did not have inpatient beds, only nursing home care unit (NHCU) beds. We confirmed with program officials at Anesthesia Service, VA Central Office, that the Directive also applies to NHCUs. If NHCUs use 911 emergency services, they should request a waiver. However, if VA providers perform emergency airway management in NHCUs, the Directive would apply.

Policy Requirements

We excluded the two facilities that called 911 from the remainder of the policy requirement review, because they did not have any providers who performed out-of-operating room airway management. We evaluated the remaining 120 local policies to determine whether they contained selected requirements specified in Directive 2005-031

regarding provider competency. Those requirements (in italics) and results are described below:

> *1. Provisions for out-of-operating room airway management that reflect the specific practice settings and circumstances of that facility, including an assessment of the number and type of clinical staff whose expected duties would include endotracheal intubation and airway management in a non-operating room setting.*

One hundred five of the 120 policies (88 percent) included a statement regarding clinical staff expectations. The NCPS sample policy included a statement that the Chief of Staff would provide an assessment of the number and type of clinical staff expected to perform non-operating room airway management. If that statement was in policies, or if they specified the exact number and type of staff, we determined they complied with the Directive. VA Central Office Anesthesia staff confirmed that the intent of the Directive was to limit the number of providers who perform emergency intubations so that they could perform enough procedures to maintain proficiency.

> *2. A process for confirming the competence of those who perform airway management that includes initial competency for privileging or establishing scope of practice and ongoing demonstration of competency for reappraisal, renewal of privileges, and scope of practice.*

The policy review demonstrated that 113 of 120 policies (94 percent) contained a description of the process for confirming competency of providers.

> *3. Documentation of procedural skill including successful endotracheal intubation of a patient and successful ventilation of an unconscious patient using a bag and mask and either an oral or nasopharyngeal airway.*

The requirements for competency include cognitive and procedural skills. Facility policies included details on procedural skill assessment for 106 of the 120 policies (88 percent).

The Directive clearly states that ACLS certification is not adequate because the training is on mannequins. The Directive requires actual patient experience. One policy we reviewed stated that because there were so few intubations at the facility, mannequins could be used to demonstrate competency. This violates the intent of the Directive.

In the policies we reviewed, the locally required minimum number of procedures per provider ranged from 1 to 15. Some smaller facilities created partnering experience with larger, VHA tertiary care medical centers. Their providers traveled to those larger facilities for OR intubation experience. Other providers documented experience at private, community medical centers to meet their minimum requirements.

4. *Use of device, along with auscultation, to confirm tube placement.*

Of the policies reviewed, 112 of 120 (93 percent) required the use of a device to confirm placement. Failure to properly intubate the trachea and ventilate a patient can result in permanent damage or death. VHA requires the use of devices to monitor tube placement.

5. *Provider-specific data analysis compared to aggregate data from providers with comparable clinical privileges.*

The Directive requires that facilities include in their policy a statement that provider-specific emergency airway management data will be compared to aggregate data to assist in the determination of competency. Ninety-four of the 120 policies (78 percent) included this statement.

6. *Designated committee oversight.*

Facilities are also required to designate a committee that will be responsible for reviewing provider-specific and aggregate data. Ninety of the 120 policies (75 percent) designated committee oversight.

Overall, when considering compliance with all six required policy elements, 71 of 120 facilities (59 percent) included all six elements. The balance (49 facilities, or 41 percent) included some but not all required elements.

Issue 2: Discrepancies Between Policy and Practice

The remainder of the inspection compared local policy requirements to actual facility practice. We requested the names and occupational categories of providers who were allowed to perform emergency out-of-operating room airway management. Occupational categories included physicians, registered nurses (including certified registered nurse anesthetists), respiratory therapists, physician assistants, dentists, emergency medical technicians, and medical residents. We then compared that list to the facility policy. There were discrepancies between those categories listed in policies compared to the list of providers. For example, a physician assistant was on the list of providers but the policy stated that only physicians could perform intubations. Another facility stated their practice was to call 911 unless a clinician was "compelled" to intubate. However, they listed 20 physicians who were allowed to intubate. Even so, in FY 2007 there had only been one intubation by a facility physician. Yet another facility listed 112 physicians who were allowed to emergently intubate. VA Central Office Anesthesia staff confirmed that the intent of the Directive was to limit the number of providers who perform emergency intubations so that they would perform enough procedures to maintain proficiency.

Issue 3: Provider-Specific Data and Committee Oversight

The final part of the review related to the requirement for provider-specific and aggregate data analysis. We requested any provider-specific quality data concerning emergency airway management for all individuals on the list of permitted providers. We reviewed the provider data to determine if there was data for each individual on the list. Only 17 of the 120 facilities (14 percent) had captured data for all providers. Some had partial data, for example, respiratory therapist data but not physician data. Several facilities submitted documentation of training and initial competence but their information did not provide evidence of ongoing competency or provide information that can be used during the clinical reprivileging process. The 17 facilities that complied with the requirement collected data on those providers who had performed emergency intubation, the number of attempts, the success of intubation, and any complications. That data was then compared to facility aggregate data to determine individual competency.

We also asked for the minutes of the designated oversight committee that reviewed both aggregate and provider-specific data concerning intubation and airway management. Only 6 of 120 facilities (5 percent) provided minutes with documentation of required data. While some facilities provided minutes with documentation of emergency resuscitation events, the minutes did not include provider-specific data.

We identified best practices at the James E. Van Zandt VA Medical Center, Altoona, PA, and the Huntington VA Medical Center, Huntington, WV, where committees compared statistical data and were able to identify the need for provider retraining or were able to verify competency for providers performing out-of-operating room airway management.

Conclusions

Some facilities that did not have acute care beds were confused regarding the implementation of the Directive. Because they only had NHCUs, the designation "inpatient facility" led to misinterpretation of requirements. If those facilities call 911 for emergency response, they need to apply for a waiver. If their providers perform out-of-operating room airway management, they must comply with the Directive.

Despite the fact that NCPS provided a sample policy, facilities had deleted required elements or made changes that altered the intent of the Directive. When considering compliance with all six required policy elements, 71 of 120 facilities (59 percent) included all six elements. The balance (49 facilities, or 41 percent) included some but not all required elements. There was variation regarding the minimum number of procedures locally required to establish and maintain competency.

We identified best practices at facilities that maintained provider-specific information on the number of procedures performed and outcomes (successful intubations, number of attempts, complications). Committees then compared that information to facility

aggregate data and discussed opportunities to improve clinical practice. That information was then used for reprivileging or renewal of scope of practice. The Hampton VA Medical Center, Hampton, VA, initiated incident reports if unauthorized providers performed intubation. Managers then discussed those incidents with the individuals and their supervisors.

The majority of facilities did not comply with provider-specific data collection for use in the reprivileging process. This review validated OIG's concern that medical centers are not able to verify provider competence to perform certain procedures. Without provider-specific information, facilities cannot measure performance and outcome or assess the competency of an individual provider's ability to perform emergency airway management.

There were 3 of the 120 facilities (less than 3 percent) that complied with all the Directive requirements that we reviewed. These were the James E. Van Zandt VA Medical Center, Altoona, PA; the Huntington VA Medical Center, Huntington, WV; and the Northern Arizona VA Health Care System, Prescott, AZ.

Recommendations

Recommendation 1. The Under Secretary for Health will ensure that VHA requires facilities that do not perform out-of-operating room airway management to apply for a waiver from VHA Directive 2005-031.

Recommendation 2. The Under Secretary for Health will ensure that VHA facilities that perform out-of-operating room airway management maintain policies that comply with all elements of VHA Directive 2005-031.

Recommendation 3. The Under Secretary for Health will require VHA facilities to collect provider specific and aggregate data regarding out-of-operating room airway management and discuss results at the designated oversight committee.

Comments

The Under Secretary for Health agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendix A, pages 10–13, for the full text of the comments.) We will follow up on planned actions until they are completed.

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

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2008

From: Under Secretary for Health (10)

Subject: Healthcare Inspection – Out-of-Operating Room Airway Management in Veterans Health Administration Medical Centers

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the report and recommendations. Although some Veterans Health Administration (VHA) facilities reviewed demonstrated compliance with all requirements of VHA Directive 2005-031, Out-of-Operating Room Airway Management, not all facilities were compliant. We will use the results of your audit to reinforce compliance with the Directive.

2. The requirement for provider-specific and aggregate data analysis is essential for performance measurement and assessment of an individual provider's ability to perform emergency airway management, and should include a review of that analysis by an oversight committee. To increase facility compliance with this component, Patient Care Services (PCS) provided facilities with a Clinical Patient Record System reminder dialog template using health factors (Endotracheal Intubation Procedure Note), which will facilitate both the provider-specific and aggregate data analysis. Further, oversight committee review of provider-specific and aggregate data will be emphasized when dialog template instructions are issued to the field next month, and will be addressed, as necessary, at the next meeting of the Under Secretary for Health's Coordinating Committee for Quality and Safety.

3. To further ensure compliance with VHA policy concerning out-of-operating room airway management, PCS will collaborate with the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to reinforce compliance at the upcoming VISN Chief Medical Officer's conference call scheduled for June

30, 2008. Patient safety, specific training, demonstrated competency, provider-specific aggregate data analysis, and waiver requirements will be emphasized. PCS and the DUSHOM will work together to develop and issue a survey to the field to assess the current state of facility compliance with the Directive, and are tasked with ensuring corrective action is taken where necessary.

4. Thank you for the opportunity to review the draft report and for incorporating our technical comments in the final report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 461-8470.

(original signed by:)

Michael J. Kussman, MD, MS, MACP

Attachment

Under Secretary for Health Comments to Office of Inspector General's Report

The following Under Secretary for Health's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

The Under Secretary for Health will:

Recommendation 1. Ensure that VHA requires facilities that do not perform out-of-operating room airway management to apply for a waiver from VHA Directive 2005-031.

Concur In process **Target Completion Date:** September 30, 2008

Patient Care Services (PCS) will collaborate with the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to reinforce the need for VHA facilities to fully comply with VHA Directive 2005-031 at the upcoming VISN Chief Medical Officers' conference call scheduled for June 30, 2008. Facilities' use of community services as first responders to emergency airway management will be discussed, with additional emphasis on the policy requirement that application and receipt of a waiver be complete before utilizing that option.

PCS and the DUSHOM will also work together to develop and issue a survey to the field by June 30, 2008, to assess the current state of facility compliance with the Directive. Assessment of survey responses and development of appropriate action for non-compliant facilities will be completed by September 30, 2008.

Recommendation 2. Ensure that VHA facilities that perform out-of-operating room airway management maintain policies that comply with all elements of VHA Directive 2005-031.

Concur In process **Target Completion Date:** September 30, 2008

Patient Care Services (PCS) will collaborate with the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to reinforce the need for VHA facilities to fully comply with VHA Directive 2005-031 at the upcoming VISN Chief Medical Officer's conference call

scheduled for June 30, 2008. Patient safety, specific training, demonstrated competency, and provider-specific aggregate data analysis, as required by the policy, will be emphasized.

PCS and the DUSHOM will also work together to develop and issue a survey to the field by June 30, 2008, to assess the current state of facility compliance with the Directive. Assessment of survey responses and development of appropriate action for non-compliant facilities will be completed by September 30, 2008.

Recommendation 3. Require VHA facilities to collect provider specific and aggregate data regarding out-of-operating room airway management and discuss results at the designated oversight committee.

Concur In process **Target Completion Date:** July 15, 2008

Provider-specific and aggregate data analysis is required by VHA Directive 2005-031. In May 2008, VHA facilities were given a CPRS reminder dialog template using health factors (Endotracheal Intubation Procedure Note). Patient Care Services (PCS) is currently working on providing facilities with instructions on how to retrieve the health factors data from this new template, which will facilitate both the provider-specific and aggregate data analysis. When PCS distributes the instructions to the field, they will also emphasize the requirement of designated oversight committee review of the provider-specific and aggregate data. This requirement will also be addressed, as necessary, at the next meeting of the Under Secretary for Health's Coordinating Committee for Quality and Safety. The dialog template instructions for retrieving the data from Vista/CPRS will be completed and issued to the field no later than July 15, 2008.

Appendix B

List of Medical Centers

Facilities That Responded to Request

Aleda E. Lutz VA Medical Center, Saginaw, MI
Alexandria VA Medical Center, Pineville, LA
Amarillo VA Health Care System (Thomas E. Creek VA Medical Center), Amarillo, TX
Asheville VA Medical Center, Asheville, NC
Atlanta VA Medical Center, Decatur, GA
Bath VA Medical Center, Bath, NY
Battle Creek VA Medical Center, Battle Creek, MI
Bay Pines VA Healthcare System, Bay Pines, FL
Beckley VA Medical Center, Beckley, WV
Birmingham VA Medical Center, Birmingham, AL
Boise VA Medical Center, Boise, ID
Butler VA Medical Center, Butler, PA
Canandaigua VA Medical Center, Canandaigua, NY
Carl Vinson VA Medical Center, Dublin, GA
Central Alabama Veterans Health Care System, Montgomery and Tuskegee, AL
Central Arkansas Veterans Healthcare System, John L. McClellan Memorial Veterans Hospital, Little Rock, AR; and Eugene J. Towbin Healthcare Center, North Little Rock, AR
Central Texas Veterans Health Care System, Olin E. Teague Veterans' Center, Temple, TX; and Waco VA Medical Center, Waco, TX
Charlie Norwood VA Medical Center, Augusta, GA
Cheyenne VA Medical Center, Cheyenne, WY
Chillicothe VA Medical Center, Chillicothe, OH
Cincinnati VA Medical Center, Cincinnati, OH
Clement J. Zablocki VA Medical Center, Milwaukee, WI
Dayton VA Medical Center, Dayton, OH
Durham VA Medical Center, Durham, NC
Edward Hines, Jr. VA Hospital, Hines, IL
Erie VA Medical Center, Erie, PA
Fargo VA Medical Center, Fargo, ND
Fayetteville VA Medical Center, Fayetteville, AR
Fayetteville VA Medical Center, Fayetteville, NC
G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS
Grand Junction VA Medical Center, Grand Junction, CO
Harry S. Truman Memorial Veterans' Hospital, Columbia, MO
Hunter Holmes McGuire VA Medical Center, Richmond, VA
Huntington VA Medical Center, Huntington, WV
Iowa City VA Medical Center, Iowa City, IA

Iron Mountain VA Medical Center, Iron Mountain, MI
Jack C. Montgomery VA Medical Center, Muskogee, OK
James A. Haley Veterans' Hospital, Tampa, FL
James E. Van Zandt VA Medical Center, Altoona, PA
James H. Quillen VA Medical Center, Mountain Home, TN
James J. Peters VA Medical Center, Bronx, NY
Jesse Brown VA Medical Center, Chicago, IL
John D. Dingell VA Medical Center, Detroit, MI
John J. Pershing VA Medical Center, Poplar Bluff, MO
Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA
Kansas City VA Medical Center, Kansas City, MO
Lebanon VA Medical Center, Lebanon, PA
Lexington VA Medical Center, Lexington, KY
Louis A. Johnson VA Medical Center, Clarksburg, WV
Louis Stokes VA Medical Center, Cleveland, OH
Louisville VA Medical Center, Louisville, KY
Marion VA Medical Center, Marion, IL
Martinsburg VA Medical Center, Martinsburg, WV
Memphis VA Medical Center, Memphis, TN
Miami VA Healthcare System, Miami, FL
Michael E. DeBakey VA Medical Center, Houston, TX
Minneapolis VA Medical Center, Minneapolis, MN
New Mexico VA Health Care System, Albuquerque, NM
North Chicago VA Medical Center, North Chicago, IL
North Florida/South Georgia Veterans Health System, Gainesville and Lake City, FL
Northern Arizona VA Health Care System, Prescott, AZ
Northport VA Medical Center, Northport, NY
Oklahoma City VA Medical Center, Oklahoma City, OK
Overton Brooks VA Medical Center, Shreveport, LA
Philadelphia VA Medical Center, Philadelphia, PA
Phoenix VA Health Care System (Carl T. Hayden Veterans Medical Center), Phoenix, AZ
Portland VA Medical Center, Portland, OR
Providence VA Medical Center, Providence, RI
Ralph H. Johnson VA Medical Center, Charleston, SC
Richard L. Roudebush VA Medical Center (Indianapolis VA Medical Center), Indianapolis, IN
Robert J. Dole VA Medical Center, Wichita, KS
St. Cloud VA Medical Center, St. Cloud, MN
St. Louis VA Medical Center, John Cochran Division and Jefferson Barracks Division, St. Louis, MO

Salem VA Medical Center, Salem, VA
Salisbury - W.G. (Bill) Hefner VA Medical Center, Salisbury, NC
Sheridan VA Medical Center, Sheridan, WY
Sioux Falls VA Medical Center (Royal C. Johnson Veterans Memorial Medical Center), Sioux Falls, SD
South Texas Veterans Health Care System, San Antonio, TX
Southern Arizona VA Health Care System, Tucson, AZ
Spokane VA Medical Center, Spokane, WA
Stratton VA Medical Center, Albany, NY
Syracuse VA Medical Center, Syracuse, NY
Tennessee Valley Healthcare System, Alvin C. York (Murfreesboro) Campus and Nashville VA Medical Center, Nashville, TN
Togus VA Medical Center, Augusta, ME
Tomah VA Medical Center, Tomah, WI
Tuscaloosa VA Medical Center, Tuscaloosa, AL
VA Ann Arbor Healthcare System, Ann Arbor, MI
VA Black Hills Health Care System, Fort Meade and Hot Springs, SD
VA Boston Healthcare System, Brockton, Jamaica Plain, and West Roxbury, MA
VA Caribbean Healthcare System, San Juan, PR
VA Central California Health Care System, Fresno, CA
VA Central Iowa Health Care System, Des Moines and Knoxville, IA
VA Connecticut Healthcare System, Newington and West Haven, CT
VA Eastern Colorado Health Care System, Denver, CO
VA Eastern Kansas Health Care System, Leavenworth (Dwight D. Eisenhower VA Medical Center) and Topeka (Colmery-O'Neil VA Medical Center), KS
VA Greater Los Angeles Healthcare System, Los Angeles, CA
VA Gulf Coast Veterans Health Care System, Biloxi, MS
VA Illiana Health Care System, Danville, IL
VA Loma Linda Healthcare System, Loma Linda, CA
VA Long Beach Healthcare System, Long Beach, CA
VA Maryland Health Care System, Baltimore and Perry Point, MD
VA Montana Health Care System, Fort Harrison, MT
VA Nebraska Western Iowa Health Care System, Grand Island, Lincoln, and Omaha, NE
VA New Jersey Health Care System, East Orange and Lyons, NJ
VA NY Harbor Healthcare System, Brooklyn and New York, NY
VA North Texas Health Care System: Dallas VA Medical Center, Dallas, TX; and Sam Rayburn Memorial Veterans Center, Bonham, TX
VA Northern California Health Care System, Mather, CA
VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana
VA Palo Alto Health Care System, Livermore, Menlo, and Palo Alto, CA

VA Pittsburgh Healthcare System, University Drive, Highland Drive, and H.J. Heinz III Progressive Care Center, Pittsburgh, PA
VA Puget Sound Health Care System, Seattle and American Lake Division at Tacoma, WA
VA Roseburg Healthcare System, Roseburg, OR
VA Salt Lake City Health Care System, Salt Lake City, UT
VA San Diego Healthcare System, San Diego, CA
VA Sierra Nevada Health Care System, Reno, NV
VA Western New York Healthcare System, Batavia and Buffalo, NY
West Palm Beach VAMC, West Palm Beach, FL
West Texas VA Health Care System, Big Spring, TX
White River Junction VA Medical Center, White River Junction, VT
Wilkes-Barre VA Medical Center, Wilkes-Barre, PA
William S. Middleton Memorial Veterans Hospital, Madison, WI
Wilmington VA Medical Center, Wilmington, DE

Facilities That Did Not Respond to Request

San Francisco VA Medical Center, San Francisco, CA
VA Pacific Islands Health Care System, Honolulu, HI
Washington DC VA Medical Center, Washington, DC
Wm. Jennings Bryan Dorn VA Medical Center, Columbia, SC

Facilities with Waivers

Coatesville VA Medical Center, Coatesville, PA
Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA
Northampton VA Medical Center, Leeds, MA
VA Hudson Valley Health Care System, Castle Point Campus, Castle Point, NY and Franklin Delano Roosevelt Campus, Montrose, NY

Facility with Waiver but Provided Airway Management and Had Policy

Hampton VA Medical Center, Hampton, VA

Appendix C

OIG Contact and Staff Acknowledgment

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 997-6971
Acknowledgments	Jennifer Kubiak, Project Manager Andrea Buck, M.D., J.D. Dorothy Duncan Reba B. Ransom Jim Seitz Marilyn Stones

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Veterans Integrated Service Network Directors (1-23)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

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