



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 07-03341-73**

# **Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, Washington**



**February 11, 2008**

**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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## Executive Summary

### Introduction

During the week of November 5–8, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Puget Sound Health Care System (the HCS). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). The HCS is part of Veterans Integrated Service Network (VISN) 20.

### Results of the Review

This CAP review covered four operational activities. We also followed up on three review areas from the prior CAP review. We identified the following organizational strengths and reported accomplishments:

- A cost-effective computerized system for tracking locally mailed controlled substances.
- An enhanced emergency drug cache storage and distribution system.

We made recommendations in three of the activities reviewed and in one of the follow-up review areas. For these three activities and the follow-up review area, the HCS needed to:

- Document strong actions when data analysis indicates problems or trends and track actions until resolution.
- Monitor timeliness of peer reviews and root cause analyses (RCAs) and take appropriate interventions when timeframes are not met.
- Perform the appropriate percentage of utilization management (UM) reviews.
- Require team members to participate in all environment of care (EOC) inspections and inspect community based outpatient clinics (CBOCs) semi-annually.
- Ensure that safety inspections of mental health units comply with Veterans Health Administration (VHA) policy.
- Require managers to secure dirty utility rooms and address the unresolved EOC deficiencies.
- Ensure that the local policy and all business rules are in compliance with VHA guidance.

- Require clinicians to consistently perform and document patient skin integrity assessments and identify patients at risk for pressure ulcers.

The HCS complied with selected standards in the following activity:

- Patient Satisfaction Survey Scores.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles Office of Healthcare Inspections.

## Comments

The VISN and HCS Directors concurred with the 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 not yet completed.

*(original signed by:)*

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

## Introduction

### Profile

**Organization.** The HCS is a two-division tertiary, teaching, and research facility located in Seattle and Tacoma, WA. The HCS provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at one VA-staffed CBOC in Bremerton, WA, and at three contracted CBOCs in Bellevue, Federal Way, and Kent, WA. The HCS serves a veteran population of about 203,000 throughout Washington, Alaska, Idaho, and Oregon.

**Programs.** The HCS provides medical, surgical, behavioral, geriatric, and rehabilitation services. It has 283 hospital, 131 nursing home, 60 domiciliary, and 30 Psychosocial Residential Rehabilitation Treatment Program beds. An additional 15 inpatient beds are available to veterans in the Tacoma area through a sharing agreement with Madigan Army Medical Center.

**Affiliations and Research.** The HCS is affiliated with the University of Washington and provides training for 511 residents and medical students and for more than 1,600 allied health trainees in various disciplines. In fiscal year (FY) 2007, the HCS research program had 667 projects and a budget of over \$40 million. Important areas of research included prosthetics and amputee care, mental illness, and neuro-degenerative disorders.

**Resources.** In FY 2007, the medical care budget was approximately \$397.9 million. FY 2007 staffing was 3,025 full-time employee equivalents (FTE), including 201.3 physician and 576.7 nursing FTE.

**Workload.** In FY 2007, the HCS treated 60,127 unique patients. The inpatient care workload totaled 9,155 discharges, and the average daily census, including nursing home patients, was 287. Outpatient workload totaled 616,972 visits.

### Objective and Scope

**Objective.** 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 objective of the CAP review is to:

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

**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 four activities:

- Business Rules for Veterans Health Information Systems.
- EOC.
- Patient Satisfaction Survey Scores.
- QM.

The review covered HCS operations for FY 2006 and FY 2007 and was done in accordance with OIG standard operating procedures for CAP reviews.

We also followed up on select recommendations from our prior CAP review of the HCS (*Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington*, Report No. 05-00523-128, April 22, 2005). We had identified improvement opportunities in the following review areas: (1) emergency preparedness (EP), (2) colorectal cancer (CRC) management, and (3) pressure ulcer management. During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate administrative and clinical actions to address the identified deficiencies in the areas of EP and CRC management. We consider these issues closed. However, since desired outcomes for pressure ulcer management had not yet been achieved at the time of this CAP review, we reissued recommendations for this area (see page 8).

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. The activity in the “Review Activities Without Recommendations” section has no reportable findings.

## Organizational Strengths

### **A Cost-Effective Computerized System for Tracking Locally Mailed Controlled Substances**

The HCS installed computerized metered mail equipment in the pharmacy for tracking package delivery and signature confirmation. This new system has decreased labor and mailing costs, improved tracking of mailed controlled substances, and decreased errors. In addition, the system uses individual employee identification codes, allowing supervisors to monitor employee performance. The HCS estimates an annual savings of \$90,000 in mailing costs and \$10,000 in labor costs with the new system.

### **An Enhanced Emergency Drug Cache Storage and Distribution System**

HCS pharmacy managers, in collaboration with the EP manager, have developed tools to facilitate efficient distribution and storage and safe use of drugs in the emergency cache cart. A master list of drugs in each cache cart is color coded according to biological, chemical, explosion/burn, and radiological emergency needs. This master list also contains the quantities of drugs in stock and specific drug administration instructions. Since clinical providers may not be familiar with some of the drugs stocked, the instructions provide quick and easy access to important drug information. In addition, a plastic toolbox kit was created that includes blank patient labels, pens, administration records, and a utility knife. Having these items organized in a toolkit box facilitates rapid medication distribution during an emergency.

## Results

### **Review Activities With Recommendations**

#### **Quality Management**

The purpose of this review was to evaluate whether the HCS’s QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program’s activities. We interviewed the HCS Director, Chief of Staff, Chief Nurse Executive, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.



The QM program was generally effective in providing oversight of the HCS's quality of care. Appropriate review structures were in place for 10 of the 14 program activities reviewed. However, we identified three areas that needed improvement.

Corrective Action Items. Although we found excellent data gathering and analysis in all required areas, improvement was needed in documenting strong actions when problems were identified. For example, UM data analysis indicated a trend in the need for more skilled nursing beds. However, no corrective actions were documented. In the areas where we did see that actions were taken, we found that follow-up tracking needed improvement.

**Recommendation 1**

We recommended that the VISN Director ensure that the HCS Director requires that service chiefs, program coordinators, and committee chairpersons document strong actions in response to data analysis that indicates problems or trends and develop tracking methods to ensure that actions are implemented and problems resolved.

The VISN and HCS Directors concurred with the findings and recommendation. The Executive Office will provide a standardized documentation format to all committees, and the use of this tool will be monitored through ongoing review of committee minutes. Target date for completion is January 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Timeliness. For FY 2007, required timeframes for both peer reviews and RCAs were not met. For example, the requirement is for RCAs to be completed within 45 days, yet the FY 2007 average was 97 days (range 67–181 days). It is important to timely complete both peer reviews and RCAs so that issues can be quickly identified and addressed and so that similar incidents can be prevented. Managers told us that the delays were partially caused by staff vacancies and that those vacancies had been filled.

**Recommendation 2**

We recommended that the VISN Director ensure that the HCS Director requires that peer review and RCA timeliness is monitored and that appropriate interventions are taken when required timeframes are not met.

The VISN and HCS Directors concurred with the findings and recommendation. Managers have already begun initiating actions to ensure timely review. They reported that since October 1, 2007, the HCS has had two RCAs and five peer reviews, and all have been completed within the 45-day timeframe. The action plan is acceptable, and we consider this recommendation closed.

Utilization Management. We found that admission and continued stay reviews were performed on all acute care units. However, the numbers indicated that less than 20 percent of FY 2007 admissions and continued stay days were reviewed. For FY 2007, VHA directives required that at least 20 percent of admission and continued stay days be reviewed. Managers told us that the low percent of reviews was partially caused by staff vacancies and that those vacancies had been filled.

### **Recommendation 3**

We recommended that the VISN Director ensure that the HCS Director requires that the percentage of UM reviews specified by VHA directives be performed.

The VISN and HCS Directors concurred with the finding and recommendation. Managers will deploy additional staff to meet review requirements, and UM processes will be integrated into the patient flow, admission, and discharge functions. Target date for implementation is April 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

### **Environment of Care**

The purpose of this review was to determine if the HCS complied with selected infection control (IC) standards and maintained a safe and clean patient care environment.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

Overall, the patient care areas we inspected (including long-term care units, primary care clinics, the locked psychiatric unit, and the pharmacy) were generally clean and well maintained. We identified four areas that needed management attention.

Environment of Care Team Inspection. The HCS EOC inspection team did not include representation from nursing management or patient safety, as required by local policy. We also found that team members' attendance at the weekly inspections was inconsistent and difficult to track. Additionally, managers did not conduct the required EOC inspections at the three contracted CBOCs. Managers needed to update the HCS policy to comply with VHA guidelines and to reflect changes in the EOC inspection process. Program managers took immediate actions, including addressing the team composition and attendance, initiating inspections of the contracted CBOCs, and updating the local policy.

**Recommendation 4** We recommended that the VISN Director ensure that the HCS Director requires that all designated team members participate in all EOC inspections and that all CBOCs are inspected semi-annually.

The VISN and HCS Directors concurred with the findings and recommendation. Managers have implemented procedures to ensure consistent participation in inspections by all EOC team members. Also, managers reported that all CBOCs were inspected as of November 9, 2007. The improvement plan is acceptable, and we consider this recommendation closed.

Mental Health Unit Safety Inspection. VHA developed the mental health EOC checklist along with the protocol to identify safety concerns on locked mental health units. The protocol specifies the establishment of a specially trained Multidisciplinary Safety Inspection Team (MSIT) and requires quarterly MSIT inspections, with all findings and actions tracked on a spreadsheet. We found that the MSIT did not include all required members and that the spreadsheets needed improvement.

We also noted that managers needed to replace the call button cords with the appropriate material and install "panic buttons" in the interview rooms at both the Tacoma and Seattle facilities. While we were onsite, the Safety Officer and the MSIT initiated changes to ensure that the cords and panic buttons comply with standards and policies; therefore, we did not make a recommendation for these items.

**Recommendation 5** We recommended that the VISN Director ensure that the HCS Director takes action to ensure that mental health unit safety inspections comply with VHA standards.

The VISN and HCS Directors concurred with the findings and recommendation. The local policy was modified to ensure that inspections of locked mental health units comply with VHA policy. The target date for implementation is January 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Dirt Utility Rooms. Medical waste regulations require that areas used to store biohazardous materials be secured. The dirty rooms had hazardous waste containers marked with appropriate labels. However, the doors had no signage and were not secure to restrict unauthorized access. This presents a potential safety hazard to patients, families, and visitors.

Unresolved Findings. In January 2007, a VISN safety report identified inappropriate storage and security of oxygen cylinders in the Respiratory Therapy Department. The report also identified inappropriate storage of boxes and inadequate cleanliness in the Prosthetic Laboratory. We inspected these areas during our site visit and noted that the deficiencies had not been resolved.

**Recommendation 6** We recommended that the VISN Director ensure that the HCS Director requires managers to secure dirty utility rooms and address the unresolved EOC deficiencies in the Respiratory Therapy Department and Prosthetic Laboratory.

The VISN and HCS Directors concurred with the findings and recommendation. The HCS Industrial Hygienist completed a risk assessment of all dirty utility rooms. Work orders will be generated for areas requiring lock changes. The target date for completion is March 2008. In addition, the oxygen cylinders in the Respiratory Therapy Department have been secured, and a thorough cleaning of the Prosthetic Laboratory area was completed. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

## **Business Rules for Veterans Health Information Systems**

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI also recommended that the ability to edit signed records be limited to the facility's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and local policies and examined more than 1,700 business rules. The HCS had a written procedure for correcting erroneous patient information. However, we identified nine business rules that did not meet the local policy regarding the reassignment or re-linking of documents. In addition, we found two erroneous rules that program managers agreed to review and address. While we were onsite, program managers provided us with an acceptable action plan.

### **Recommendation 7**

We recommended that the VISN Director ensure that the HCS Director requires program managers to update the local policy, correct or delete erroneous rules, and conduct periodic reviews of all business rules to ensure full compliance with VHA policy.

The VISN and HCS Directors concurred with the findings and recommendation. The local policy has been updated, and a review of business rules has been completed. An annual review of business rules will be performed, and findings will be reported to the Clinical Documentation Committee. The improvement plan is acceptable, and we consider this recommendation closed.

## **Pressure Ulcer Management**

We followed up on recommendations from our prior CAP review related to pressure ulcer management. We reviewed data collection and trend analysis reports and saw evidence

of progression toward improved patient outcomes and decreased prevalence rates for hospital-acquired pressure ulcers. However, managers and clinicians acknowledged that documentation deficiencies related to skin integrity assessments and patient risk identifications exist throughout the HCS. Managers agreed that the proposed corrective actions in response to the recommendations in our prior CAP report had not been fully implemented. Therefore, we are reissuing our prior recommendations to ensure that the HCS continues to follow up.

**Recommendation 8** We recommended that the VISN Director ensure that the HCS Director requires clinicians to consistently perform and document patient skin integrity assessments.

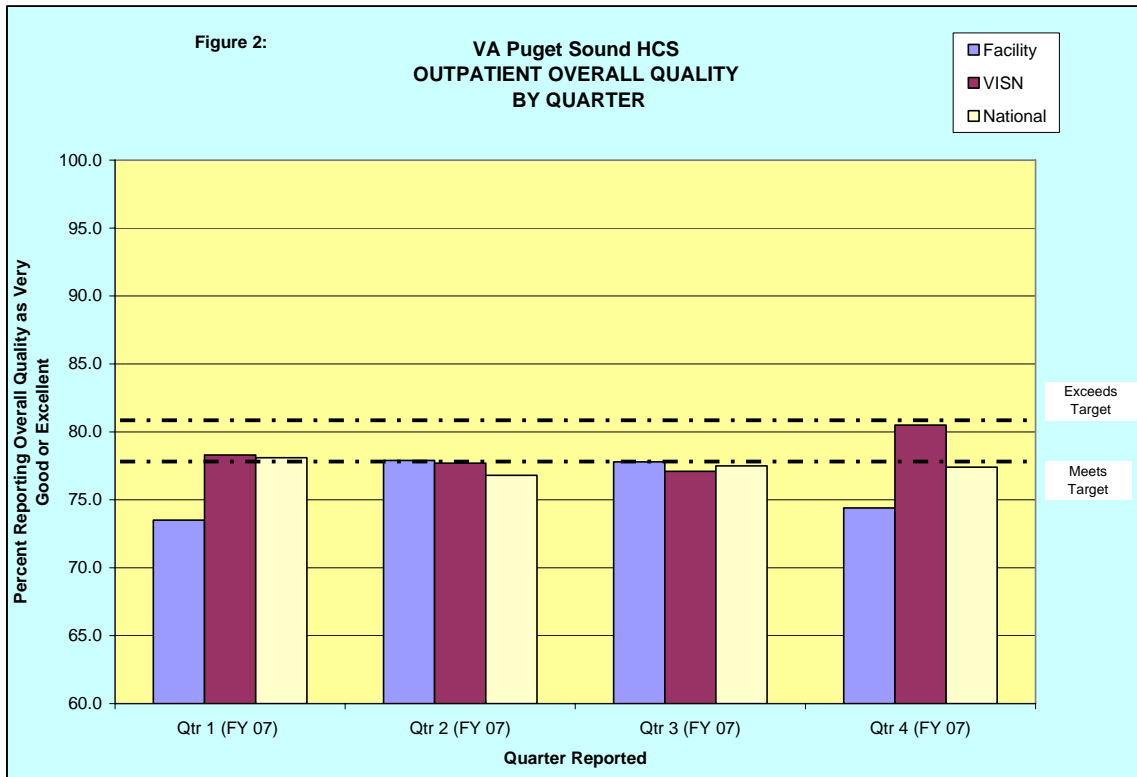
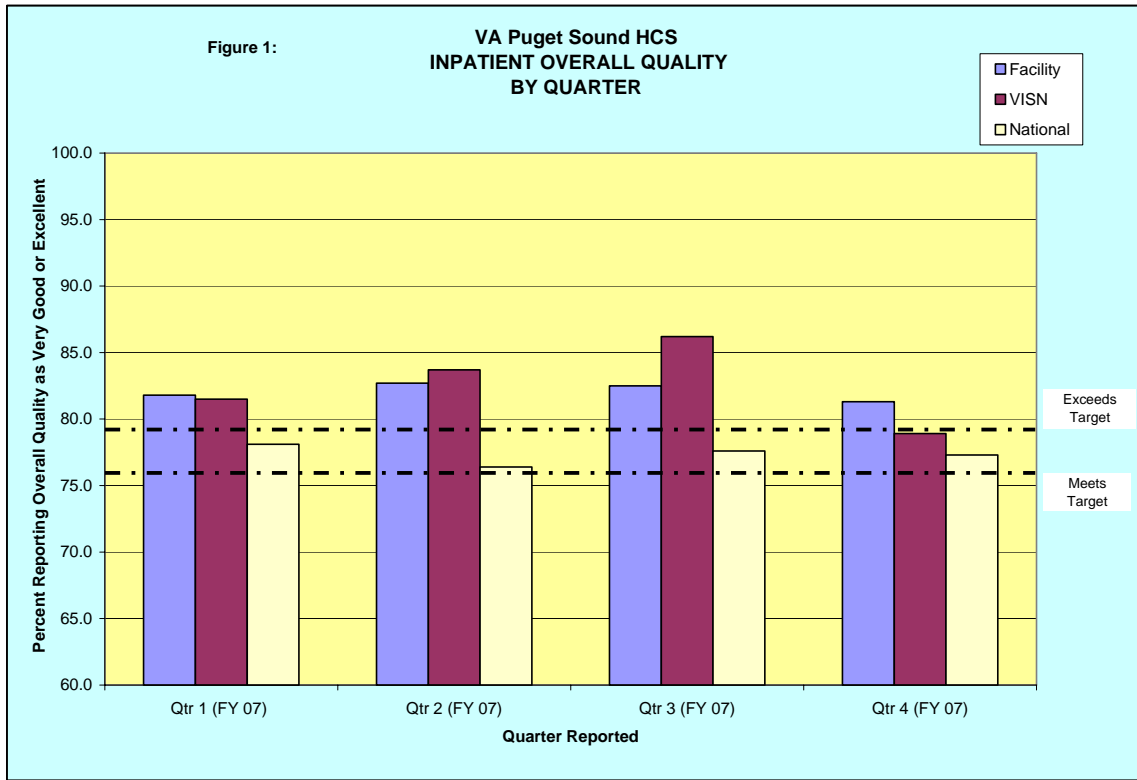
**Recommendation 9** We recommended that the VISN Director ensure that the HCS Director requires clinicians to identify patients who are at risk for pressure ulcers and follow procedures for preventing pressure ulcers.

The VISN and HCS Directors concurred with the findings and recommendations. The Nursing Service policy was updated to reflect the current requirements on skin assessment. In addition, managers have implemented the skin assessment template outlined in the VHA Nursing Service guidance. Nurse managers will gather data through medical record reviews to meet the national data roll-up requirements and to comply with the skin integrity program requirements. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

## Review Activities Without Recommendations

**Patient Satisfaction Survey Scores** The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figure 1 on the next page shows the HCS's patient satisfaction performance measure results for inpatients, and Figure 2 on the next page shows the HCS's patient satisfaction performance measure results for outpatients.



The HCS's scores exceeded the national average in all inpatient areas. Managers had implemented action plans to improve satisfaction with outpatient care. We found the action plans acceptable, and we made no recommendations.



## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** December 20, 2007

**From:** VISN Director (10N20)

**Subject:** **Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington**

**To:** Director, Los Angeles Healthcare Inspections Division (54LA)  
Director, Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the VA Puget Sound Health Care System, Seattle, WA.
2. If you have any questions regarding this report, please contact Sherri Bauch, Assistant Director, at (206) 764-2299.

*(original signed by DeAnn Dietrich for:)*  
Dennis M. Lewis, FACHE

Attachments

## Health Care System Director Comments

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 HCS Director requires that service chiefs, program coordinators, and committee chairpersons document strong actions in response to data analysis that indicates problems or trends and develop tracking methods to ensure that actions are implemented and problems resolved.

**Concur.**

**Target date of implementation/completion: January 7, 2008**

**Planned Action:** Executive Office will provide a standardized format to all committees by January 7, 2008. Monitor use of tool through ongoing review of committee minutes by the executive office.

**Recommendation 2.** We recommended that the VISN Director ensure that the HCS Director requires that peer review and RCA timeliness is monitored and that appropriate interventions are taken when required timeframes are not met.

**Concur.**

**Target date of implementation/completion: October 1, 2007**

**Planned Action:** RCA completion time is monitored at the facility and through the network. Since October 1, 2007, we have had two RCAs and five peer reviews, and all have been completed under the 45-day timeframe.

**Recommendation 3.** We recommended that the VISN Director ensure that the HCS Director requires that the percentage of UM reviews specified by VHA directives be performed.

**Concur.**

**Target date of implementation/completion: April 1, 2008**

**Planned Action:** We will add staff to meet the Directive requirements. We will be integrating the processes of utilization management reviews into the patient flow and admission and discharge functions.

**Recommendation 4.** We recommended that the VISN Director ensure that the HCS Director requires that all designated team members participate in all EOC inspections and that all CBOCs are inspected semi-annually.

**Concur.**

**Target date of implementation/completion: November 9, 2007**

**Planned Action:** A review of all CBOCs was completed on November 9, 2007, and the rounds schedule has been revised to review semi-annually, with the next review to be completed on May 16, 2008. Implemented a sign-in sheet for inspections in October 2007 and instituted procedures to assure full participation on a consistent basis when a member cannot attend rounds, including designation of a person with similar expertise to attend in his/her place. If this is not possible, then the member must complete an individual review of the area within one week so that any additional findings can be added to the inspection report.

**Recommendation 5.** We recommended that the VISN Director ensure that the HCS Director takes action to ensure that mental health unit safety inspections comply with VHA standards.

**Concur.**

**Target date of implementation/completion: January 15, 2008**

**Planned Action:** The local Behavioral Health EOC Rounds (BHEOCR) Policy was modified to ensure that all components of the National Center for Patient Safety guide for conducting inspections of Locked Mental Health Units includes the recommended BHEOCR team members. Changes have been implemented to the policy, and the final policy is in concurrence with issuance expected by January 15, 2008.

**Recommendation 6.** We recommended that the VISN Director ensure that the HCS Director requires managers to secure dirty utility rooms and address the unresolved EOC deficiencies in the Respiratory Therapy Department and Prosthetic Laboratory.

**Concur.**

**Target date of implementation/completion: March 1, 2008**

**Planned Action:** A risk assessment of dirty utility rooms was completed by the Industrial Hygienist in November 2007. Areas requiring lock changes based on the risk assessment were identified, and a list of room numbers and locations is currently being assembled. Work orders will be generated to assure appropriate locks are installed to secure dirty utility rooms containing hazardous materials by March 2008. Respiratory Therapy oxygen cylinders have been secured. Prosthetic Laboratory areas were thoroughly cleaned by Facilities Management in November 2007. Posters have been provided in Prosthetic Laboratory, reminding employees about proper use of cardboard.

**Recommendation 7.** We recommended that the VISN Director ensure that the HCS Director requires program managers to update the local policy, correct or delete erroneous rules, and conduct periodic reviews of all business rules to ensure full compliance with VHA policy.

**Concur.**

**Target date of implementation/completion: December 17, 2007**

**Planned Action:** The 2007 review of business rules was completed in November 2007, and all rules have been updated. Health Information Management Service (HIMS) and Clinical Application Coordinators (CAC) will conduct the future annual reviews and report findings to the Clinical Documentation Committee. VA Puget Sound Health Care System Memorandum IM-03 Health Information Management and Health Records have been updated.

**Recommendation 8.** We recommended that the VISN Director ensure that the HCS Director requires clinicians to consistently perform and document patient skin integrity assessments.

**Concur.**

**Target date of implementation/completion: December 1, 2007**

**Planned Action:** Since the OIG visit, the nursing service policy has been updated to reflect the current requirements outlined in VHA Directives on Skin Assessment. We have implemented the skin assessment template outlined in the VACO Nursing Service guidance December 1, 2007. Nurse Managers will gather data through medical record reviews to meet national data roll up requirements and show local compliance with meeting the skin integrity program requirements.

**Recommendation 9.** We recommended that the VISN Director ensure that the HCS Director requires clinicians to identify patients who are at risk for pressure ulcers and follow procedures for preventing pressure ulcers.

**Concur.**

**Target date of implementation/completion: December 1, 2007**

**Planned Action:** Since the OIG visit, the nursing service policy has been updated to reflect the current requirements outlined in VHA Directives on Skin Assessment. We have implemented the skin assessment template outlined in the VACO Nursing Service guidance December 1, 2007. Nurse Managers will gather data through medical record reviews to meet national data roll up requirements and show local compliance with meeting the skin integrity program requirements.

## **OIG Contact and Staff Acknowledgments**

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<b>Contact</b>	Julie Watrous, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
<b>Contributors</b>	Daisy Arugay, Associate Director Gail Bozzelli, Healthcare Inspector John Tryboski, Senior Management and Program Analyst

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