Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Consultant Responses, Nurse Staffing, Deep Dives, and Communication
VA Illiana Health Care System
Danville, Illinois

Report No. 12-00828-287

September 26, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding pharmacy response, surgical and mental health consultant response times, nurse staffing, deep dives (a process to assess and improve patient care), and inadequate leadership communication regarding proposed changes at the VA Illiana Health Care System (HCS) (facility) in Danville, IL.

We did not substantiate that Surgical and Pharmacy Services are not providing timely services when requested as required by the Veterans Health Administration directives and facility policy. We did substantiate that the Mental Health Service did not respond to "emergency," "within one hour (STAT)," and "within 24 hours" consults for patients diagnosed with suicidal ideation within facility policy timeframes. Patients, however, are kept on a one-to-one observation basis until evaluated and cleared by a psychiatrist.

We did not substantiate that nursing leadership was deficient in its staffing plans. However, we did substantiate that nurse staffing on two units did not comply with unit staffing plans. We substantiated that registered nurses were assigned to units without the required unit competencies validated as required by The Joint Commission. Registered nurses that were reassigned to other units were also not consistently provided unit orientation prior to working on the units as required by facility policy.

We did not substantiate that punitive action was taken against an employee based on results of a deep dive facility review. We found that this employee no longer works at the facility. However, Human Resource staff told us that this employee did not receive disciplinary action.

We also did not substantiate that facility leadership has not communicated with staff proposed changes, including facility capabilities. Leadership has made many attempts to keep staff informed of the proposed changes. The facility has current policies in place addressing treatment options and facility capabilities.

We recommended that the Facility Director ensure: mental health consults are answered and documented within the timeframe specified by the referring provider, referring providers follow the facility's consult policy when submitting emergency and STAT consults, nurse staffing follows the nursing hours per patient day as determined by nursing methodology, and nurses have documented unit-specific orientation and competencies for any unit assigned.

The Veterans Integrated Service Network and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.

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

TO: Director, Veterans in Partnership (10N11)

SUBJECT: Healthcare Inspection – Consultant Response Time, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations concerning consultant response times, nurse staffing, deep dives (a process to assess and improve patient care), and communication at the VA Illiana Health Care System (HCS) (facility) in Danville, IL.

Background

The facility is part of Veterans Integrated Service Network 11 located in Ann Arbor, MI. It provides inpatient and outpatient healthcare services to a veteran population of approximately 136,000 in a primary service area that includes Peoria, Decatur, Mattoon, and Springfield, IL; and West Lafayette, IN.

The facility provides acute medical, surgical, and psychiatric care, and extended long-term and skilled nursing home care. It has 54 hospital beds, 176 community living center (CLC) beds, an emergency department (ED), and an intensive care unit (ICU).

The facility's Surgical Service has consult service agreements with Primary Care, Geriatrics and Extended Care, and Acute Care Services. General surgery provides elective, urgent, and emergent surgical consultation. Surgical Service agrees to examine patients the same day for urgent and emergent general surgical conditions after the referring clinician has completed an initial assessment. The facility's Mental Health Service has consult service agreements with Geriatrics and Extended Care, Medical, and Surgical Services. Mental Health Service psychiatrists or psychologists are to respond to referrals for consultation in a timely manner. The referring clinician will choose a level of urgency from options based on clinical necessity and severity of symptoms:

For Inpatients:

- "Within one hour (STAT)." The consulted clinician will see the patient as promptly as possible, but no later than 1 hour from the time of request. The referring clinician must contact the consultant or service chief/designee to discuss the patient's clinical presentation and need for consultation.
- "Within 24 hours."
- "Within 48 hours."
- "Within 72 hours."
- "Within 1 month (routine)."

For Outpatients:

- "Within one hour (STAT)." The consulted clinician will see the patient as promptly as possible, but no later than 1 hour from the time of request. The referring clinician must contact the consultant or service chief/designee to discuss the patient's clinical presentation and need for consultation.
- "Today/close-of-business."
- "Within 24 hours."
- "Within 1 month (routine)."

The consultant may contact the referring physician if he/she thinks that the level of urgency or the consult itself is inappropriate.

Surgical Service

In Fiscal Year (FY) 2010, the facility decreased the complexity of surgeries performed. It no longer provides subspecialty orthopedic services. General surgeons are available on site Monday through Friday, 7:30 a.m. to 4:00 p.m. A Surgeon on Call (SOC) must be available 24 hours a day. The SOC is responsible for all admissions and consultations after the regular tour of duty and inpatient rounds on weekends and holidays. The SOC is required to be available for an in-person consultation within 45 minutes.

Mental Health Service

The facility provides inpatient and outpatient mental health treatment. Inpatient services are provided on an acute psychiatric closed unit for patients presenting as a danger to self and/or others. The facility has psychiatrists available onsite Monday through Friday, 7:30 a.m. to 4:00 p.m., and covering the acute mental health unit on Saturday and Sunday. When on-call, they are required to respond to a telephone call within 10 minutes, and be onsite at the facility within 90 minutes, if needed.

Pharmacy Service

The Veterans Health Administration (VHA) requires pharmacy services to be sufficient to meet the needs of patients. If a facility does not provide inpatient pharmacy services 24 hours a day, 7 days a week, a telepharmacy[1] and/or "an on-call" duty roster must be developed and maintained.[2]

The facility staffs its inpatient pharmacy Monday through Friday, 7:00 a.m. to 11:00 p.m. and on Saturday, Sundays, and holidays from 7:30 a.m. to 4:00 p.m. The facility has a contract with a pharmaceutical services company to approve inpatient orders placed after hours. If a physician requests a medication that is not readily available, the pharmacist will contact the requesting physician to determine if an alternative medication can be used, or if medication administration can wait until the next morning. If there is no substitution, or medication administration cannot wait, the on-call pharmacist will come to the facility to retrieve the medication from the pharmacy.

Nurse Staffing

As of September 2011, VHA requires facilities to use a standardized method to determine appropriate direct care staffing for VA nursing personnel for all inpatient points of care.[3] This includes defining the target nursing hours per patient day (NHPPD) for specific care settings to ensure adequate nursing personnel across the organization. Per facility policy, staffing levels are adjusted temporarily for each tour based upon patient census, acuity, and need. In the event changes are needed, staff may be assigned to other areas of the facility.

The Joint Commission requires that staff are competent to perform their responsibilities. Staff competence is to be assessed and documented once every 3 years or more frequently as required by hospital policy. The facility has developed both core and unit registered nurse (RN) competencies. Additionally, per facility policy, when a nurse is assigned to another unit, the nurse is provided with "Just-In-Time"[4] unit orientation.

Quality Management

The Patient Safety Program's goal is to prevent harm to patients. One method used is Root Cause Analysis (RCA). An RCA identifies the basic or contributing factors associated with adverse events or close-calls.[5] In addition to RCA's, the facility started a

[1] Telepharmacy is a way to provide real-time pharmacy services to patients at remote locations.
[2] VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
[3] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
[4] Just-In-Time unit orientation is training provided to the staff member when the day's unit assignment changes to an unfamiliar unit and the orientation occurs just prior to starting the work on the unfamiliar unit.
[5] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

less formal, faster process to assess and improve patient care issues known as deep dives. Like RCAs, deep dives emphasize prevention rather than punishment.

Allegations

In November 2011, during a Combined Assessment Program review, the Office of Healthcare Inspections received allegations concerning consultant response times, nurse staffing, deep dives, and communication at the facility. A complainant alleged that:

- Surgeons, psychiatrists, and pharmacists do not provide care within requested timeframes after hours, specifically:
    - When a surgeon is called for a patient with an acute abdomen[6] after hours, staff are told to admit the patient, and the surgeon will see the patient in the morning.
    - Patients with suicidal ideation are kept on one-to-one observation, sometimes over an entire weekend, while waiting to be seen by psychiatrists who will not see patients for suicidal ideation after hours or on weekends.
    - An on-call pharmacist would not come to the facility after hours to provide a needed medication and instructed the nurse to tell the physician to substitute a medication of a completely different drug class for the prescribed one.
- Nurse staffing is inappropriate on inpatient units, specifically:
    - The facility has not developed staffing guidelines in approximately 1.5 years and units are not staffed safely.
    - Nursing staff are being reassigned to unfamiliar units without proper training.
- The facility took punitive action against an employee based on the findings of a deep dive review in contrast to the intent of the exercise.
- Facility administration does not clearly communicate to staff what services are available at the facility; specifically, who can be treated at the facility; who needs to be transferred to another facility; and how such patients are to be transferred.

Scope and Methodology

We conducted a site visit on April 17–18, 2012. We interviewed managers, clinicians, and other employees knowledgeable in the area of the allegations. We reviewed pertinent electronic health records, policies, directives, and personnel records. The Office of

[6] An acute abdomen is when the abdomen is in severe pain and often needs surgical intervention. This condition requires a quick medical decision for management to prevent serious complications, including death.

Healthcare Inspections statisticians analyzed the unit-level NHPPDs based on the actual units' census.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Consultant Responses after Hours and on Weekends

Surgical Service

We did not substantiate that surgeons do not provide care within requested timeframes after hours or on weekends. From March 20, 2011, through April 4, 2012, the facility had 25 general surgery consults submitted for weekends, after-hours, and holidays. For these 25 consults:

- Two were discontinued appropriately.
- Twenty-one were completed within the timeframe requested.
- One STAT consult was not answered until the next morning because the patient required further testing before the consultant could properly address the issues raised by the requesting physician.
- One STAT consult was entered for a patient who came into the ED for a draining abscess. Although a surgeon did not see the patient that night, ED staff made the patient an appointment in the surgery clinic the next morning.

There were 10 non-elective surgical admissions to the facility during the timeframe referenced. Surgeons admitted four patients after scheduled outpatient abdominal surgeries. The other six patients were also promptly attended, requiring minor surgical procedures or non-surgical care only.

Psychiatric Service

Psychiatrists are not responding to consultation requests after hours. We substantiated that psychiatrists do not provide care for suicidal ideation patients within requested timeframes after hours and on weekends. We reviewed all mental health consults submitted from March 20, 2011 through April 4, 2012, which were marked as either "emergency," "within one hour (STAT)," "today," or "within 24 hours." There were 55 consults requested for suicidal ideation. We found that 32 (58 percent) had documentation of a response from a mental health provider within the requested timeframe. For the other 23 patients, wait times ranged from 24 hours to 45.15 hours. These patients were placed on one-to-one observation by nursing staff until they were cleared by a psychiatrist or transferred to the mental health inpatient service.

No documentation of phone consultation. A STAT consult requires that the referring physician contact a mental health provider. The mental health provider, depending on the situation, may not need to see the patient immediately and can advise the referring physician over the phone and see the patient later. As most of these phone consultations are not documented in the patients' electronic health record, there is no way of knowing the actual response time.

Referring providers are not calling when they enter STAT mental health consults. A STAT consult requires that the referring physician contact a mental health provider. The mental health provider, depending on the situation, may not need to see the patient immediately and can advise the referring physician over the phone and see the patient later. Many ED staff members interviewed stated that psychiatrists do not come in after hours or on the weekends, so there is "no point in calling them" to let them know that a consult is being submitted. Mental health staff confirmed the lack of notification regarding STAT consults during our interviews.

Entering consults as STAT instead of "within 24 hours." We found several consults with an urgency of STAT, but in the text of the consult, the provider requested the psychiatrist to see the patient within 24 hours. Some staff, when interviewed, did not know that an urgency of "within 24 hours" was an option.

Because ED staff generally believed that it was acceptable for psychiatrists to not respond to consults during off duty hours, staff had not reported these issues to mental health managers. When managers became aware of the problem they initiated ongoing education to referring physicians on when to contact mental health service regarding consults and on selection of the right level of consult urgency as determined by the patient's condition.

Pharmacy Service

We did not substantiate that pharmacists do not provide care within requested timeframes after hours or on weekends, or that a pharmacist refused to come to the hospital after hours to provide medication for a patient when prescribed by a physician. According to the complainant, an on-call pharmacist told a nurse to inform a patient's physician to substitute another class of medication for the one requested when it was not available at night. The patient did not receive the medication prescribed by the physician and required transfer to an outside hospital for further care.

We reviewed the electronic health records of all patients transferred from the facility to an outside hospital in FY 2010 and FY 2011 with the above patient's particular condition and did not find a case where a specific medication requested by a physician prior to transfer had not been provided.

We interviewed physicians and nurses concerning their experiences with on-call pharmacists and found that no one had experienced a pharmacist refusing to come to the facility.

Issue 2: Nurse Staffing

Development of Staffing Guidelines

We did not substantiate the allegation that the facility did not have staffing guidelines in place. We found staffing plans were developed in FY 2011, revised in FY 2012, and changes were made in March 2012 when inpatient units were re-organized.

Staffing Levels

We assessed the staffing plans and patterns based on the targeted medical surgical unit (58-2) and CLC (1-3) NHPPD, and the actual NHPPD based on the actual patient census reported by the facility for the two units. The sample time period consisted of preset randomly selected dates ranging from October 1, 2011, through March 31, 2012, in three groups (i.e. holidays, weekdays, and weekends).

Figure 1 gives the sampled actual and targeted unit NHPPD for the medical surgical unit in the review period. Figure 2 shows that the medical surgical unit's average actual NHPPD staffing levels was statistically significantly (at the significant level 0.05) above the target NHPPD in the sample period. When looking at the actual staffing levels by holidays, weekdays, and weekends separately, we found that only the average staffing level on weekdays was statistically significantly above the targeted NHPPD.

Figure 1: Sampled Actual NHPPD for the Medical Surgical Unit 58-2 October 1, 2011–March 31, 2012

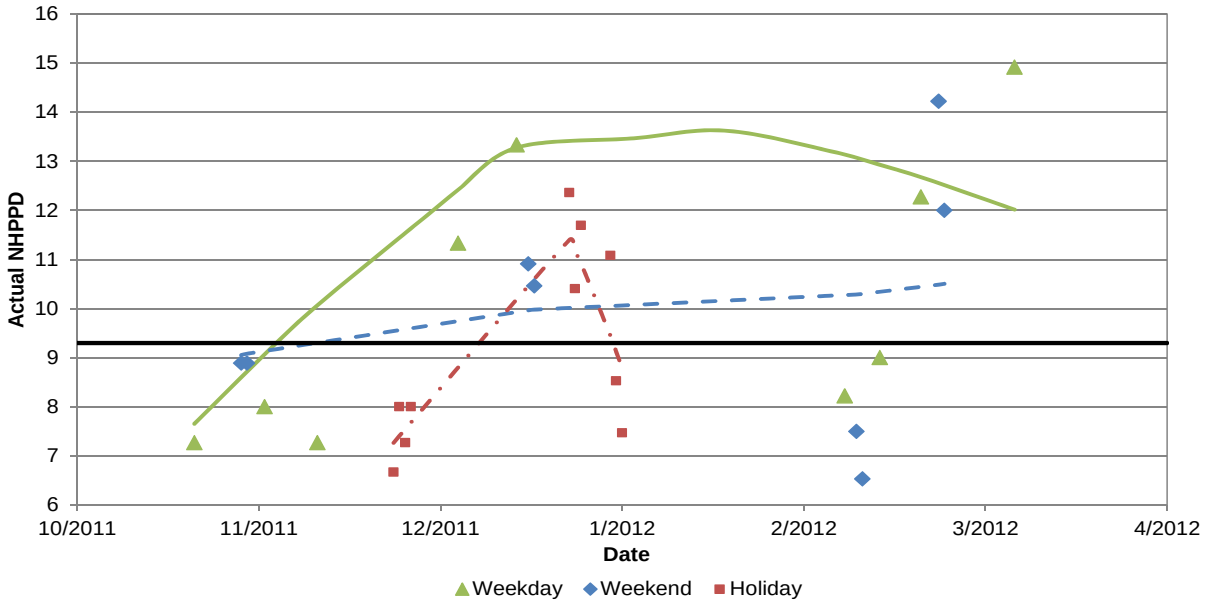

Figure 2: Estimated NHPPD and Daily Patients for Unit 58-2
October 1, 2011–March 31, 2012

	NHPPD				Patients (Census)			
	Sample Size	Mean	95% Confidence Interval	Estimate is Statistically Signficantly Different from the Target (**9.30**)	Sample Size	Mean	95% Confidence Interval	Estimate is Statistically Signficantly Different from the Target (**14.00**)
Holiday	10	9.15	*		10	12.20	*	
Weekday	11	12.32	(9.541, 15.095)	Above	11	12.00	(9.596, 14.404)	No
Weekend	8	9.93	(6.15, 13.7)	No	8	12.00	(6.343, 17.657)	No
Overall	**29**	**11.53**	**(9.622, 13.439)**	**Above**	**29**	**12.01**	**(10.187, 13.835)**	**Below**

** All holiday-related data are reviewed.*

Additionally, we assessed the staffing plans and patterns based on the targeted and actual CLC NHPPD, and actual CLC patient census reported by the facility for the same sample time period (Figure 3 and Figure 4). Figure 4 shows the overall average actual NHPPD mean of 5.7 is statistically significantly below the CLC target of 7 NHPPD. The average NHPPDs on holidays, weekdays, and weekends were all below the facility target.

Figure 3: Sampled Actual NHPPD for CLC Unit 1–3
October 1, 2011–March 31, 2012

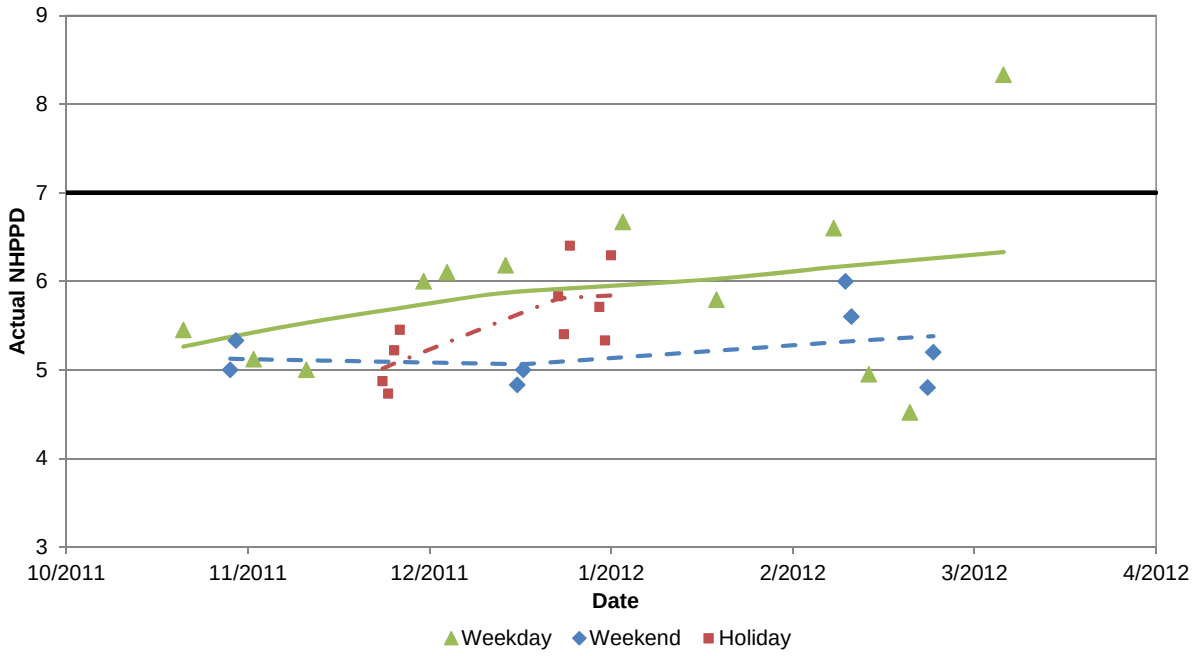

Figure 4: Estimated NHPPD and Daily Patients for CLC Unit 1–3
October 1, 2011–March 31, 2012

	NHPPD				Patients (Census)			
	Sample Size	Mean	95% Confidence Interval	Estimate is Statistically Signficantly Different from the Target (**7.00**)	Sample Size	Mean	95% Confidence Interval	Estimate is Statistically Signficantly Different from the Target (**24.00**)
Holiday	10	5.52	*		10	21.80	*	
Weekday	11	5.89	(5.273, 6.512)	Below	11	21.00	(19.054, 22.946)	Below
Weekend	8	5.22	(4.638, 5.802)	Below	8	22.00	(18.645, 25.355)	No
Overall	**29**	**5.70**	**(5.286, 6.113)**	**Below**	**29**	**21.30**	**(19.920, 22.682)**	**Below**

** All holiday-related data are reviewed.*

Nursing Competency

We substantiated that RNs are sometimes assigned to work in units without proper training. We reviewed the competency folders and the Just-In-Time training records for 10 RNs that were assigned from the medical unit and ED to other clinical areas. Five of the medical unit RNs had been assigned to either the ED or the ICU in the past year; however, the competencies for the medical unit are not the same as those for the ED and ICU. We did not find documented competencies for the five medical unit RNs to work in the ED or the ICUs.

Only two RNs who were assigned to the CLC had Just-In-Time unit orientation. There are five CLCs and each has different Just-In-Time orientation requirements. Interviewed staff confirmed that they were not oriented to the alternate units assigned. Facility Leadership agreed that Just-In-Time unit orientation, especially on the evening and night shifts, was not consistently being done.

Issue 3: Deep Dives

We did not substantiate that punitive action resulted from a deep dive. The facility conducted two deep dives between March 20, 2011, and April 4, 2012. The staff member cited by the complainant as receiving punitive action after a deep dive no longer works at the facility. Human Resources staff did not find any evidence of disciplinary action taken prior to the employee's resignation.

Issue 4: Communication

We did not substantiate that leadership does not communicate what services are available at the facility, or the process for transferring a patient to an outside hospital. We found facility policies in place that specify what medical and surgical conditions physicians can and cannot treat at the facility. The facility also has policies describing how to transfer patients to an outside hospital.

Due to difficulties in staffing subspecialty positions to support the ICU and low patient volumes, the ICU has not accepted patients since November 2011. Facility

leadership discussed this change during All Employee Meetings on March 28, 2011, October 12, 2011, and January 17, 2012; during Medical Staff Meetings on May 23, 2011, September 26, 2011, and November 16, 2011; and during two Town Hall meetings on August 26, 2011. When the ICU initially stopped taking patients, a notification memorandum was sent to all staff.

Conclusions

We found the Surgical and Pharmacy Services to be providing care as required by VA directives and facility policy. We found evidence that the Mental Health Service does not reliably respond to emergency, STAT, and "within 24 hours" consults as required by facility policy.

Nursing leadership has staffing plans in place; however, the staffing on the two units we reviewed was not consistent with the facility's determined NHPPD for those units. In addition, nurses float to units without validated unit competencies as required by The Joint Commission. Additionally, nurses assigned to other units are not consistently provided Just-In-Time unit orientation prior to working on the units as required by facility policy.

Deep dives' results were not used to take punitive action against an employee.

The facility has been researching options on how to serve its veteran population, including changing the ED to an urgent care center and closing the ICU. Leadership has made many attempts to keep staff informed of the proposed changes. The facility has policies in place addressing treatment options and facility capabilities.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that mental health consults are answered and documented within the timeframe specified by the referring provider.

Recommendation 2. We recommended that the Facility Director ensure that referring providers follow the facility's consult policy when submitting emergency and STAT consults.

Recommendation 3. We recommended that the Facility Director ensure that nurse staffing follows the NHPPD as determined by nursing methodology.

Recommendation 4. We recommended that the Facility Director ensure that nurses have documented unit-specific orientation and competencies for any unit assigned.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2012

From: Director, Veterans in Partnership (10N11)

Subject: **Healthcare Inspection – Consultant Response Time, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (VHA 10AR MRS)

1. Attached is VA Illiana Health Care System's response to the draft report.

2. If you have any questions, please contact Kelley Sermak, Quality Management Officer, at 734-222-4302.

Michael S. Finegan
Director, Veterans in Partnership (10N11)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2012

From: Director, VA Illiana Health Care System (550/00)

Subject: **Healthcare Inspection – Consultant Response Time, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois**

To: Director, Veterans in Partnership (10N11)

1. Listed are individual responses to the recommendations from the survey.

2. Please contact Lori Pearman, Quality Manager, at 217-554-5083 if you have any questions on the information provided.

Nirmala J. Rozario M.D.

for Emma Metcalf, MSN, RN
Director, VA Illiana Health Care System (550/00)

Director's 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's report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that mental health consults are answered and documented within the timeframe specified by the referring provider.

Concur **Target Completion Date:** December 15, 2012

Facility's Response:

Mental Health Service is required to conduct weekly review of all consults ordered for timeliness of completion and documentation. All consult monitors are reviewed at the facility's Clinical Executive Committee monthly.

Status: Open

Recommendation 2. We recommended that the Facility Director ensure that referring providers follow the facility's consult policy when submitting emergency and STAT consults.

Concur **Target Completion Date:** December 15, 2012

Facility's Response:

The facility Consult Policy was revised to reflect the ordering capabilities of CPRS and clarification of the level of urgency. A discussion at the facility medical staff meeting was held regarding the policy changes, along with ordering of consults based on clinical necessity and severity of symptoms. It was also reiterated at this meeting that Psychiatry services were available 24/7. A weekly monitor is being conducted by each service to ensure timeliness, completion, and appropriateness of consults.

Status: Open

Recommendation 3. We recommended that the Facility Director ensure that nurse staffing follows the NHPPD as determined by nursing methodology.

Concur **Target Completion Date:** December 15, 2012

Facility's Response:

Nursing Service staffing plans are in alignment with the NHPPD as determined by staffing methodology. This was accomplished by the development of a facility-wide staffing calculator and quick reference guide that mirrors the approved FY 2012 NHPPD for each unit. Education was provided to Chief Nurses, Nurse Managers, and Nursing Supervisors on the use of the staffing calculator. Variances are tracked on a shift-by-shift basis and are reviewed by the Chief Nurse of Operations to identify outliers and/or recommended changes. Additionally, 24-hour electronic staffing sheets have been implemented to provide a complete picture of available staff throughout the facility.

Status: Open

Recommendation 4. We recommended that the Facility Director ensure that nurses have documented unit-specific orientation and competencies for any unit assigned.

Concur **Target Completion Date:** October 31, 2012

Facility's Response:

Nursing Leadership has developed a Nursing Service Office Memorandum (NSOM) that outlines a comprehensive plan for initial competency, unit/position specific competency, and Just-In-Time (JIT) competency for nursing staff. All nursing areas have identified unit specific JIT competencies. The forms have been developed and are located on the nursing shared drive. Nursing staff that are floated to other units will complete these competencies upon arrival. Nursing service is in the process of standardizing the documentation process for competencies. Each unit will be provided binders to store all current annual and JIT competency forms. Competencies for previous 2 years will be stored in the CTOPS folder, per facility policy.

Status: Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Gayle Karamanos, MS, PA-C, Team Leader Rose Griggs, MSW, LCSW Thomas Jamieson, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst Lin Clegg, PhD, Biostatistician Nathan McClafferty, MS, Management Program Analyst Patrick Smith, MS, Mathematical Statistician Jarvis Yu, MS, Management and Program Analyst

Appendix D

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