

VIRGINIA: IN THE CIRCUIT COURT OF THE COUNTY OF ALBEMARLE

DR. K. CRAIG KENT )

*Plaintiff,* )

v. )

JONES SWANSON HUDDALL LLC, )  
GLADSTONE JONES, LYNN SWANSON, )  
and LES BOWERS )

*Defendants.* )

Case No. )

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**COMPLAINT**

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Plaintiff, Dr. K. Craig Kent, for his Complaint against Defendants, Jones Swanson Huddell LLC (a law firm), and individuals Gladstone Jones, Lynn Swanson, and Les Bowers, states as follows:

**OVERVIEW**

1. Dr. Kent files this litigation in response to Defendants’ defamatory campaign to oust him from his position as CEO of the University of Virginia Health System (“**UVA Health**”) through the publication of shocking -- and demonstrably false -- accusations about him to the UVA Board of Visitors and later, to the news media. Dr. Kent asserts claims for defamation *per se* and tortious interference with his employment contract with UVA Health.

2. The purpose of Defendants’ campaign was to remove Dr. Kent as the apex leader of UVA Health and then capitalize monetarily on his removal, by filing a federal lawsuit that echoes many of the same defamatory accusations and uses Dr. Kent’s ouster to validate them. The campaign laid the groundwork for a lawsuit to be brought by all Defendants on behalf of a group of plaintiffs. Defendants have also used press media to convey threats to file additional suits,

ostensibly to pressure UVA Health and its insurers to settle all claims and produce and an outsized financial award for Defendants.

3. As a result of Defendants' acts, Dr. Kent is entitled to compensation for the monumental injuries he suffered to his business and personal reputations, for his humiliation, emotional and mental anguish, and embarrassment, as well as for pecuniary losses (including millions of dollars in lost wages and future employment opportunities), and punitive damages.

4. At the time the Defendants' defamatory campaign began, Dr. Kent was a nationally renowned leader of medical health systems who had worked for forty years to reach the pinnacle of his profession.

5. On February 24, 2025, Defendants Jones Swanson Huddell LLC, a Louisiana law firm, Mr. Gladstone Jones (the firm's founding member), and Ms. Lynn Swanson (the firm's managing member), published a 26-page letter "report" that defamed Dr. Kent (the "**Letter Report**") to at least 23 recipients, most of whom were members of the University of Virginia Board of Visitors. (See **Exhibit A** hereto.). The publication date (February 24, 2025) was one day before the UVA Board of Visitors was scheduled to meet for briefing by Williams & Connolly attorneys on the results of their investigation of Dr. Kent (and others at UVA Health).

6. The Letter Report made shocking and false factual accusations against Dr. Kent, including that he had "ordered" a pediatric oncologist to perform an unsafe bone marrow transplant on a child patient and caused patients to become blind and suffer strokes by mismanaging UVA Health's funds.

7. The Letter Report was published on Jones Swanson Huddell letterhead, was authored by Defendants Mr. Jones and Ms. Swanson, and was attached to an email blast Defendant Mr. Jones sent from the jonesswanson.com e-mail server.

8. Defendants Jones Swanson Huddell LLC, Mr. Jones, and Ms. Swanson designed the Letter Report to appear as if it were the result of an official, objective investigation by UVA, although they were neither engaged by UVA nor directed to prepare any report. The only investigation sanctioned by UVA was performed by Williams & Connolly, and Defendants drafted the Letter Report to create the false impression that it was prepared in collaboration with the Williams & Connolly lawyers performing the investigation. The Letter Report did not result from any legitimate investigation; what Board members received was a biased and spiteful polemic against Dr. Kent based on a host of demonstrably false “facts.”

9. The Letter Report was followed by a threatening message: within twenty-four hours of its delivery, a Board of Visitors member warned the remaining board members and UVA President James Ryan that if Dr. Kent was not gone by 6:00 p.m. that day (February 25, the day of the Board meeting), it would be sent to *The Washington Post*.

10. On the afternoon of the February 25 meeting, Dr. Kent received an urgent phone call from President Ryan, who asked Dr. Kent to resign. President Ryan said the urgency was related to a threat to release the Letter Report to *The Washington Post* if Kent did not resign by 6:00 p.m. that evening.

11. Just over a year before receiving President Ryan’s call, Dr. Kent had declined the opportunity to become the CEO of a major top-twenty academic health system. His contract would have included a five-year term and more than \$6 million in total annual compensation. Dr. Kent chose to stay to finish the good work that was being accomplished at UVA Health, and out of loyalty to all of the team members that had rallied around UVA Health’s strategic plan.

12. The motive for the takedown of Dr. Kent became evident several months later when a 105-page complaint with thousands of pages of attachments was filed against him (and others)

on October 3, 2025. It makes many of the same accusations as in the Letter Report (adding, for good measure, that he had “illicitly caused the deaths of two patients”), and features Dr. Kent’s ouster as lending credence to them. Sure enough, lead counsel for the plaintiffs in that lawsuit are the Jones Law Firm Defendants, and local counsel is Defendant Les Bowers. It became clear that Defendants had been laying the groundwork in the Letter Report for a series of lawsuits that would potentially produce great financial gain for them—which meant they had every incentive to publish knowingly false information, or at the least, recklessly ignore the possibility that it was false.

13. The splashy and spurious allegations made against Dr. Kent in the complaint generated media attention, which Defendants Messrs. Jones and Bowers used as a platform to further disseminate their false messages about Dr. Kent outside the judicial proceedings and to defame Dr. Kent in the process.

14. In news articles published in October and November 2025, Messrs. Jones and Bowers were quoted as making false statements of purported fact that Dr. Kent engaged in “criminal acts” and “illegal” and “unethical” practices, all related to billing fraud, including that he had implemented a Medicare “scam.” These gratuitous, public-facing statements were neither material to nor made during a judicial proceeding.

15. Defendants published statements in the Letter Report and in the press that were defamatory *per se* because the statements imputed an unfitness to perform or lack of integrity in Dr. Kent’s performance of his job, falsely asserted that Dr. Kent committed a criminal offense involving moral turpitude, and necessarily prejudiced Dr. Kent in his profession.

16. Defendants made their defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements’ probable falsity, and/or entertained serious

doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. Defendants also published the defamatory statements with common law malice, in that Defendants acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

### **THE PARTIES**

17. Plaintiff, Dr. Craig Kent, is a resident of Charlottesville, Virginia. Immediately prior to becoming the CEO of UVA Health in 2020, Dr. Kent served as Dean of The Ohio State University College of Medicine and Vice President for Health Services. He oversaw the physician practice, increased faculty by several hundred, made significant advancements in faculty culture, and created a new physician compensation plan. In addition, Dr. Kent significantly improved the research rankings of the college and expanded its research infrastructure. For most of Dr. Kent's tenure at Ohio State, he reported directly to the university President and co-led the health system with the hospital CEO. In that role, Dr. Kent significantly expanded the clinical enterprise and enhanced the health system's national reputation.

18. Prior to Ohio State, Dr. Kent served as Chair of the Department of Surgery at the University of Wisconsin. Over eight years, Dr. Kent doubled the department's surgical volume and grew its National Institute of Health (NIH) ranking to fifth in the nation.

19. Dr. Kent began his almost thirty years of health system leadership as Chief of the Combined Division of Vascular Surgery at Weill Medical College at Cornell University and Columbia College of Physician and Surgeons. He also led the Vascular Service Line at New York Presbyterian Hospital. Dr. Kent also has served in other major national leadership roles, including President of the Society of Vascular Surgery, Chair of the American Board of Surgery, President of the Society of Surgical Chairs, and Chair of the Surgery and Bioengineering study section of

the NIH. In 2019, Dr. Kent was elected by his peers to become a member of the National Academy of Medicine, a group of 2,500 of the nation's foremost scholars, innovators, and academic leaders committed to scientific excellence and public service in medicine.

20. An NIH-funded researcher for over thirty years, Dr. Kent has authored more than 360 articles, 65 book chapters, served on multiple medical journal editorial boards, and lectured nationally and internationally at over 130 institutions. His work has been cited over 25,000 times in medical literature. He earned his medical degree and completed surgical training at The University of California, San Francisco, followed by a research and clinical fellowship in vascular surgery at The Brigham and Women's Hospital in Boston. Dr. Kent began his career in Boston where he rose to become an Associate Professor of Surgery at Harvard Medical School.

21. Defendant Jones Swanson Huddell LLC ("JSH") is a law firm based in New Orleans, Louisiana. JSH maintains its principal offices at 601 Poydras Street, Suite 2655, New Orleans, Louisiana 70130.

22. Defendant Gladstone Jones ("Jones") is an attorney and the founding member of JSH. On information and belief, Jones resides at 4130 Cove Garden Road, North Garden, Virginia 22959.

23. Defendant Lynn Swanson ("Swanson") is an attorney and the managing member of JSH. On information and belief, Swanson resides at 5701 Sutton Place, New Orleans, Louisiana 70131. (JSH, Jones, and Swanson are sometimes collectively referenced as "Jones Law Firm Defendants").

24. Defendant Les Bowers ("Bowers") is an attorney who resides in Charlottesville, Virginia at 512 Rookwood Place, Charlottesville, Virginia 22903.

## JURISDICTION AND VENUE

25. This Court has original and general jurisdiction of this case pursuant to Va. Code § 17.1-513.

26. Venue is proper pursuant to Va. Code §§ 8.01-262(1), -262(2), -262(3), and -262(4).

27. The court has personal jurisdiction over JSH, Jones and Swanson pursuant to Va. Code § 8.01-328.1(1) and (3) because the causes of action arise out of their transaction of business in this Commonwealth and causing tortious injury by acts or omissions in this Commonwealth.

## BACKGROUND

### **In 2020, UVA Health hired Dr. Kent to turn around a flagging health system.**

28. In February of 2020, UVA hired Dr. Kent to serve as the CEO of University of Virginia Health and Executive Vice President of Health Affairs at UVA for a five-year term under an employment agreement. When Dr. Kent arrived in 2020, morale was poor across the organization. His initial review revealed a lack of unity among the various health system entities (hospitals/physician organization/school of medicine), no strategic plan, poor economic performance, and a billing and collection crisis that had garnered national attention. UVA Health was decades behind benchmarks for modern healthcare, with long wait times, poor patient access, and a lack of operating practices and efficiencies. Six weeks after Dr. Kent arrived, the COVID pandemic began.

29. Despite the abrupt onset of the pandemic, UVA Health rallied under Dr. Kent's leadership. He created and implemented a comprehensive strategic plan using input from more than 3,000 team members. The initiatives focused on modernizing operations and infrastructure, achieving superior patient outcomes, and improving resource stewardship and philanthropy. The comprehensive plan was intended to foster a healthier workplace, achieve distinction in education,

lead statewide and regional expansion, and develop destination programs for clinical care. It aimed to establish UVA Health as the nation's leading public academic health system.

30. Five years later, it was clear that Dr. Kent's execution of the plan was successful.

31. Patient access to care at UVA Health increased dramatically over Dr. Kent's tenure: outpatient encounters increased by 55% to 1.3 million, surgeries by 65%, hospitalizations by 60%, emergency room visits by 300%, and cancer care by more than 70%.

32. The expansion in care volume did not come at the expense of quality, which also improved dramatically, as measured by two well-recognized metrics. Mortality rates (as measured by Vizient) dropped to their lowest levels in ten years under Dr. Kent's leadership, and all four UVA Health hospitals achieved a Leapfrog Hospital Safety Grade of "A" (the highest possible grade) by the Spring of 2024.

33. UVA Health had historically used national survey organization Press Ganey to measure engagement scores for its 18,000 team members. These scores had been low and stagnant for years prior to Dr. Kent's arrival, but increased by over 15% during his tenure. Dr. Kent's work also improved retention of existing employees and boosted recruitment of new talent: nursing and staff turnover rates were amongst the lowest in the nation at 9% and 11%; the annual faculty departure rate in the School of Medicine was one of the lowest in the nation at 5.1%; and there was the successful recruitment of over 550 new faculty, sixteen new department chairs, and thousands of new staff. These dedicated team members made possible the significant expansion of clinical care, education and research that Dr. Kent planned to achieve with the comprehensive plan. This success was related to multiple new health system initiatives focused on culture.

34. To develop the scale necessary for long term success, UVA Health acquired three hospitals and a physician practice and became a minority owner of a large, private five-hospital system in Eastern Virginia.

35. Health system philanthropy dollars tripled, with UVA Health raising over \$1 billion as part of the university's most recent campaign. Research funding in the School of Medicine grew by over \$60 million, revenue from intellectual property doubled, and two new centers were formed from major gifts: the Harrison Center for Neurodegenerative Translational Research (a \$30 million gift) and the Paul and Diane Manning Institute of Biotechnology designed to develop new therapeutics for Virginians and beyond (a \$100 million gift).

36. UVA became the first Comprehensive Cancer Center in Virginia, UVA Health Children was recognized as the #1 Children's Hospital in Virginia, and *Newsweek* named UVA Medical Center as the #1 Hospital in Virginia (and 46th in the country). In the 2024 *Forbes* rankings of America's Best Large Employers, UVA Health ranked No. 117 overall and No. 24 among health systems in the nation. It was the only Virginia-based health system named to the list.

37. Dr. Kent built enduring partnerships with other institutions which could affect the achievement of the comprehensive plan objectives. Increased collaboration with the Commonwealth of Virginia yielded an \$18 million increase in annual state funding for the cancer center, resources for the institute of biotechnology, and resources for indigent care. UVA Health excelled in community engagement by holding over 200 outreach events each year focused on identifying and connecting with those in need of care. Growth and service level improvements of this scale required intensive investment, but UVA Health remained fiscally stable throughout Dr. Kent's tenure due to excellent financial management. Annual operating revenue nearly doubled from \$2.5 billion in 2019 to \$4.7 billion in 2025.

38. In December 2023, UVA honored Dr. Kent's achievements with a new five-year contract extension through February 1, 2030. Dr. Kent's new contract included, annually, \$1.6 million in base salary plus an additional \$500,000 in bonus and deferred compensation. In its public announcement of the contract extension on December 8, 2023, UVA underscored the performance of UVA Health under Dr. Kent's leadership:

Under Kent's leadership, all four UVA Health medical centers earned "A" Hospital Safety Grades for fall 2023 from The Leapfrog Group, a national nonprofit that rates hospitals on how well they provide high-quality patient care. Kent and his team have also maintained financial stability despite the pandemic, staffing shortages and inflation, while many hospital systems throughout the country suffered substantial financial losses.<sup>1</sup>

Dr. Kent's achievements for UVA Health during the pandemic were exceptional, even by the standards of the nation's leading hospital systems that UVA Health had identified as its future peers.

**A vocal minority of UVA doctors resisted change and accountability.**

39. When Dr. Kent arrived in February 2020, virtually every aspect of UVA Health was in a state of crisis. As Dr. Neal Kassell, former Co-Chair of Neurosurgery at UVA Health, observed:

*When Kent and Kibbe commenced their leadership, UVa Health was an institution in decline, saddled with negative momentum. Once, UVa's School of Medicine boasted 10 departments in the U.S. News & World Report's top 50 health systems. When they arrived, there were none. The headwinds they faced included:*

- *Fragmented organization with friction between the UVa Physicians Group and the health system and billing dysfunction.*
- *Low productivity.*
- *Poor morale.*
- *Faculty resistant to change and accountability.*

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<sup>1</sup> *Board Extends Contract of UVA Health CEO*, UVA Today, Dec. 8, 2023. Available at: <https://news.virginia.edu/content/board-extends-contract-uva-health-ceo>. Accessed February 21, 2026. Permanent link: <https://perma.cc/PKH4-GA8C>.

- *Vocal opposition from a fraction of the clinical faculty hostile to the new CEO selection.*
- *Clinics with extraordinarily long wait times for appointments.*
- *Severe staff shortages of nurses and technologists.*
- *Coding and billing dysfunction.*
- *Public controversy over billing and collection practices.*
- *Financial instability.*
- *A Board of Visitors and administration that lacked the bandwidth, experience and expertise to manage the complexities of an academic health system. (Dealing with the issues of higher education and athletic enterprises is challenging enough even without the issues of academic medicine.)*
- *A health system operating board that lacked authority to drive meaningful change.*
- *And the COVID-19 pandemic.*

*A seismic shift with systemic reform was necessary, and the leadership acted with great alacrity. They have implemented cultural and operational changes to align UVa Health with other leading academic medical centers.<sup>2</sup>*

40. Dr. Kent’s predecessor, Dr. Rick Shannon, who also was an outsider, had attempted reforms, including greater control over physician billing and accountability. A small group of vocal and well-connected doctors, led by a surgeon who was central in the ouster of both Drs. Shannon and Kent, started a campaign against Dr. Shannon. That campaign included letter writing and complaints accusing Dr. Shannon of being dictatorial, autocratic, incompetent, and responsible for compromised safety standards. Their unjustified criticisms and internal sabotage efforts eventually caused Dr. Shannon’s resignation.

41. The same physician group, with the same surgeon leader who was passed over for the job Dr. Kent now held, began organizing their group’s complaints against Dr. Kent even before his arrival in 2020. In September of 2021, in the middle of the COVID crisis, that same group sent

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<sup>2</sup> *Dr. Neal Kassell: Kent and Kibbe are the best leaders Uva Health has had in 40 years, The Daily Progress, Mar. 14, 2025. Available at: [https://dailyprogress.com/opinion/column/article\\_c18c89ba-0017-11f0-8a73-37b9db5815d6.html](https://dailyprogress.com/opinion/column/article_c18c89ba-0017-11f0-8a73-37b9db5815d6.html). Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/MC73-PCEH>.*

a letter to UVA President Ryan, complaining that Dr. Kent exhibited behaviors identical to his predecessor, Dr. Shannon.

**UVA hired Williams & Connolly to investigate and report on complaints concerning Dr. Kent made by a small minority of disgruntled doctors.**

42. The drumbeat of this disgruntled group of doctors continued and culminated in a letter of no confidence concerning Dr. Kent, dated September 5, 2024, which was left unsigned by 128 anonymous physicians and employees (out of 1,475 faculty physicians and 18,000 employees of UVA Health). To at least three former Rectors of the University of Virginia, the letter appeared as a second act to the tactic previously used to pressure Dr. Shannon. The letter of no confidence was organized by the same core group of doctors and contained the same complaints levied at Dr. Kent's predecessor. These Rectors wrote as follows in reaction to the September 5, 2024, no confidence letter:

The blowback from all these changes was predictable. Dr. Kent's strategic reforms had produced some winners; but also, some losers. Letters of protest were sent to Dr. Kent's superior, President Jim Ryan

In the Fall 2024, a group of 128 physicians signed a letter calling for the dismissal of Craig Kent and the Dean of the School of Medicine, Dr. Melina Kibbe. They alleged mismanagement, endangerment of patients and even suggested possible financial fraud....

Longer serving members of the Health System Operating Board who had witnessed the defenestration of Dr. Shannon saw something familiar. Many of these allegations against Dr. Kent could well have been lifted -- nearly verbatim -- from the complaints made against Dr. Shannon by some of the same physicians 6 years earlier.<sup>3</sup>

43. What most readers did not realize is that the majority of the complaints against Dr. Kent and his team, beginning with his arrival and extending through his five-year tenure, had

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<sup>3</sup> *Physicians who ousted UVA Health CEO motivated by greed, officials say*, The Daily Progress, Mar. 31, 2025. Available at [https://dailyprogress.com/news/local/business/health-care/article\\_1c3bbd65-95d1-4df8-9779-8bdf1524ff79.html](https://dailyprogress.com/news/local/business/health-care/article_1c3bbd65-95d1-4df8-9779-8bdf1524ff79.html). Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/D8V5-3ZTY>.

already been investigated by internal UVA entities, including compliance, legal, and human resources— and all were found to have no merit. This included an internal investigation of the accusations regarding billing malfeasance.

44. Following receipt of the no confidence letter, the UVA Board of Visitors retained the law firm of Williams & Connolly to investigate and report on the complaints made in that letter. Williams & Connolly was the only firm retained by UVA to investigate the complaints.

45. At or around this time, the Jones Law Firm Defendants began their defamatory campaign against Dr. Kent. It was later revealed that one of the disgruntled doctors was connected to the Jones Law Firm Defendants; he was the stepbrother of Defendant Jones.

#### **THE DEFAMATION OF DR. KENT BY DEFENDANTS**

##### **The Jones Law Firm Defendants hijacked the official Williams & Connolly investigation with their own unauthorized “report.”**

46. In mid-January 2025, the Jones Law Firm Defendants learned that Williams & Connolly in their initial report to the Board of Visitors had found no evidence of financial malfeasance. The Jones Law Firm Defendants also learned that Williams & Connolly, instead of issuing a formal, written report, would make only an oral presentation to the Board in late February. The Board meeting was set for February 25, 2025.

47. The February 25, 2025, meeting (which was an in-person meeting at which some board members could not be present) was simply for the purpose of receiving Williams & Connolly’s findings, as opposed to taking any formal action on them. As outlined in an email from the Board Chair, these findings would then be discussed a little over a week later, at the regularly scheduled quarterly Board meeting on March 6, 2025. At this March meeting the entire Board of Visitors would be present, as well as members of the Health System Committee, and all could discuss the findings and possible actions.

48. The Jones Law Firm Defendants feared that Williams & Connolly's oral report to the Board would not be sufficient to cause Dr. Kent and his team's ouster. They also feared that waiting until March 6 to act on any findings presented by Williams & Connolly at the February 25 meeting would give Dr. Kent the opportunity to rebut them. Their solution was to preemptively shock the Board into action by sending them a false, but seemingly official, letter report. Concurrently, they would create time pressure with a conveyed ultimatum that Dr. Kent's employment needed to end that day—or a media firestorm would ensue caused by release of the unsolicited Letter Report to *The Washington Post*. The timing would leave Dr. Kent no meaningful opportunity to defend himself.

49. Thus, on February 24, 2025, the Jones Law Firm Defendants published their Letter Report, which was a 26-page letter, with 212 pages of attachments, and which falsely accused Dr. Kent of egregious misconduct, such as:

- *“Order[ing] a pediatric oncologist to perform a bone marrow transplant on a child - one of the rarest and most high-risk procedures in medicine -- without the necessary staffing, equipment or supplies.... .”*
- *“Mismanagement of funds”*
- *Causing “patients going blind, suffering strokes, and other catastrophic health failures.”*
- *“Retaliat[ing] against physicians who questioned their policies, even when their questions included patient safety and protection for medical providers at UVA Health during COVID.”*

50. The Letter Report was published on Jones Swanson Huddell letterhead (suggesting institutional authorization), was authored by Defendants Mr. Jones and Ms. Swanson (who authorized its publication), and was attached to an email blast sent by Defendant Mr. Jones (from the jonesswanson.com e-mail server) to 23 recipients, most of whom were members of the University of Virginia Board of Visitors.

51. The Jones Law Firm Defendants published their Letter Report to the Board of Visitors 24 hours in advance of the in-person meeting, to ensure both that board members had the time to read, review, and assimilate all of the accusations, and that Dr. Kent had no opportunity to respond.

52. The Jones Law Firm Defendants timed, structured, and phrased their Letter Report in such a way as to lead recipients to believe it was UVA's official report (i.e., a result of the Williams & Connolly investigation), or a collaboration with Williams & Connolly.

53. The Jones Law Firm Defendants, however, had never been commissioned by UVA to perform any investigation or report. The only investigation sanctioned by UVA was Williams & Connolly's. Their strategy was successful; at the Board meeting the next day, several members expressed their belief that the Letter Report was the result of Williams & Connolly's months-long investigation.

54. The Jones Law Firm Defendants achieved that effect by, in their Letter Report, conflating their "investigation" with Williams & Connolly's investigation—even though they had no official role whatsoever in that latter investigation. For example:

- They stated that the factual support for most of the statements in the letter are from "interview(s) with W&C."<sup>4</sup>
- They stated that JHS "assisted 35 doctors ... who provided information and documentation to Williams & Connolly in the context of those interviews."<sup>5</sup>
- They even went so far as to refer to their letter as "this investigation by Williams and Connolly" ("In the midst of ... **this investigation by Williams and Connolly.**")<sup>6</sup>

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<sup>4</sup> See Ex. A, fn. 1-196 (179 of the 196 footnotes in the Letter Report rely on such an interview for support).

<sup>5</sup> *Id.* at p. 1.

<sup>6</sup> *Id.* at p. 3 (emphasis added).

- For good measure, they closed their letter with a conclusion titled “**Answering Questions from Williams and Connolly.**”<sup>7</sup> At a minimum, the efforts made it appear that their letter was a collaboration with Williams & Connolly.

55. The Jones Law Firm Defendants also deliberately structured their Letter Report in a manner to make it appear that their statements of purported fact were well documented and supported—when they were not. The Letter Report includes an Appendix of 32 exhibits (totaling 212 pages), but the footnotes in the 26-page letter that reference the supposedly supporting documents in the appendix do not include the exhibit number where the referenced document can be found. A reader attempting to check the cited source would need to navigate through the entire Appendix to identify the referenced document. This method of citation could scarcely be useful to a reader, would be foreign to any trial attorney, and helped disguise the fact that the Letter Report, in actuality, does not attach any transcripts, summaries or other records of the cited interviews. Indeed, while the Letter Report cites dozens of “interview(s) with W&C,” nowhere in the Appendix are there any statements from these interviews.

56. Likewise, the Letter Report states that the Jones Law Firm Defendants, as part of their investigation, worked with 35 doctors interviewed by Williams & Connolly (and one UVA Physicians Group board member). Yet the Jones Law Firm Defendants never interviewed Dr. Kent, their prime target, or any other target, even though they were interviewed by Williams & Connolly as well. Moreover, they did not interview the remainder of the 1,450 faculty in the school of medicine, or the remainder of the 18,000 employees of UVA Health. They interviewed only 36 individuals, who represented a very small minority of the individuals at UVA Health.

57. The Jones Law Firm Defendants engaged in this partisan effort to sway Board members eager to read findings of a supposed official report. And they emailed their Letter Report

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<sup>7</sup> *Id.* at p. 26 (emphasis in original).

on February 24 not only to all Board members, but also to the Williams & Connolly attorneys, ostensibly in the hope of influencing the tenor or content of their oral presentation to be made the following day.

58. As a result of those efforts, some Board members believed that they had received the official investigation of the university (*i.e.*, the Williams & Connolly report), or at least a report from a law firm who was objectively collaborating with the official investigator. What they received instead was a biased and partisan denunciation of Dr. Kent, based on false facts. Even for the Board members that did not have that understanding, the egregious accusations with certainty influenced their views of Dr. Kent and his leadership team.

59. The Board members also became aware that the Letter Report would be given to *The Washington Post* if Dr. Kent was not ousted immediately, which President Ryan directly cited in his telephone call to Dr. Kent.

60. This forced a hasty and precipitous decision that day (February 25), depriving Dr. Kent and his team the opportunity to address the Williams & Connolly findings and to review the unsolicited Letter Report and prove its falsehoods.

#### **THE DEFAMATORY STATEMENTS IN THE LETTER REPORT PUBLISHED BY THE JONES LAW FIRM DEFENDANTS**

- ***The false statements of purported fact that Dr. Kent ordered a pediatric oncologist to perform a bone marrow transplant on a child without the necessary resources.***

61. At page 26 of their Letter Report, the Jones Law Firm Defendants published the statement that Dr. Kent had “ordered” a pediatric oncologist to perform an unsafe bone marrow transplant on a child:

*But would other healthcare executives order a pediatric oncologist to perform a bone marrow transplant on a child—one of the rarest and most high-risk procedures in medicine—without the necessary staffing, equipment, or supplies? Would they badger that oncologist to go ahead with a transplant even after he objected that it would be dangerous*

to the child? \* \* \***Dr. Kent... ha[s] done all these things**, which is why so many physicians have risked their careers to call for their resignation.<sup>8</sup>

62. Likewise, earlier in their Letter Report, the Jones Law Firm Defendants published many times the statement that Dr. Kent had “repeatedly pressured” this pediatric oncologist to perform such unsafe procedures on children with cancer:

- a. **“How Dr. Kent has repeatedly pressured a pediatric oncologist to conduct unsafe procedures on children with cancer.”<sup>9</sup>**
- b. **“Dr. Kent’s constant pressure to perform unsafe bone marrow transplants on children”<sup>10</sup>**
- c. *“Meanwhile, Dr. Lee said, Dr. Kent has repeatedly pressured him [Dr. Lee] to go ahead with transplants using staff who don’t have the required training.”<sup>11</sup>*
- d. *“Since the three oncologists left over the summer, he [Dr. Lee] told Williams & Connolly, Dr. Kent has actually pushed him to go ahead and perform a transplant on a child as the sole physician.”<sup>12</sup>*
- e. *“Dr. Kent has also asserted pressure on Dr. Lee’s supervisors. Mike Engel, Dr. Lee’s division chief, wrote to him in June 2023 that his program was ‘under considerable scrutiny...The health system leadership team seems willing to make abrupt changes when programs to which they have committed resources are underperforming... I have heard it mentioned that some have suggested pulling the plug on pediatric transplant.’”<sup>13</sup>*
- f. *“He [Dr. Lee] described how he worried that ‘harm will come to these kids’ if he - - the only barrier to Dr. Kent’s insistence of conducting an unsafe marrow transplant on a child -- were taken down.”<sup>14</sup>*

63. These appalling statements of purported fact – that Dr. Kent “ordered” Dr. Lee to perform, without the necessary resources, one of most high-risk surgeries on children – were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants

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<sup>8</sup> *Id.* at p. 26.

<sup>9</sup> *Id.* at p. 6 (twice) (emphasis in original).

<sup>10</sup> *Id.* at p. 8 (emphasis in original).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at p. 9.

are liable. Dr. Kent had no communication with Dr. Lee during his entire tenure at UVA Health about any medical procedure, much less pediatric transplants or resources to support these procedures.

64. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

65. Their Letter Report cited no support whatsoever for the statement that Dr. Kent had "ordered" Dr. Lee to perform such surgeries. It identifies no such communications and none of the documents attached to their letter reference any such communications.

66. Their Letter Report also cited no support for their first three statements of Dr. Kent "pressuring" Dr. Lee to do so (quoted above in Paragraphs 62(a), (b), and (c)). Further, instead of citing to its own interview of Dr. Lee (referenced in footnote 47 of their Letter Report), the Jones Law Firm Defendants cite Dr. Lee's "interview with W&C" as factual support for statements (d) and (f) above yet they do not include any notes, summaries, or transcript of that interview. As support for the purported statement in ¶ above, the Jones Law Firm Defendants cite to an email exchange<sup>15</sup> which does not reference Dr. Kent.

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<sup>15</sup> *Id.* at p. 8, fn.56.

67. Having interviewed Dr. Lee, and reviewed his emails about transplants, the Jones Law Firm Defendants knew that there was no evidence of any communication between Dr. Kent and Dr. Lee about transplants, or anything else.

68. At best, the Jones Law Firm Defendants blindly relied on the assertions of Dr. Lee, which itself was in reckless disregard as to whether the statements were true or false. Apparently, they never asked for documentation of any actual communications between Drs. Kent and Lee or made an effort to interview Dr. Misra (Chair of Pediatrics) or Dr. Engel (Chief of Pediatric Oncology). Nor did they try to interview Dr. Kent who, after all, was the target of the shocking claims.

- ***The false statements of purported fact that Dr. Kent hired and promoted unqualified surgeons.***

69. The Jones Law Firm Defendants repeatedly published in their Letter Report the statement that Dr. Kent hired and promoted unqualified surgeons:

- a. *“It has been Dr. Kent's hiring strategy, ..., that has caused the most distress among UVa physicians and the most harm to UVa patients. Time and again, Dr. Kent [has] dismissed UVa policy and the findings of their own protocol-established search committees, in order to force the hire of their own, hand-picked choices. Worse, once they've chosen their candidates, they have tried to control any due diligence about them by warning other physicians to support their choices, whether or not they agreed with them. And when these new physicians have shirked their duties, or proved to be unqualified, Dr. Kent ...ha[s] not only turned a blind eye to these problems, but retaliated against other physicians who reported the risk they presented to patients.”<sup>16</sup>*
- b. *In the fall of 2024, UVa's Credentials Committee initiated an investigation of multiple questionable patient outcomes associated with two cardiac surgeons that Dr. Kent ... had hired and championed throughout the past year. They continued to promote these surgeons not only through their hiring process, but even after UVa residents, senior surgeons, nurses, quality officers, and Credentials Committee members had warned that these surgeons had exhibited bizarre behaviors in the operating room and put patients' lives in 'grave risk.' Indeed, they continued to promote at least one of these physicians publicly as one of UVa's best, at the time*

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<sup>16</sup> *Id.* at p. 2-3.

*an internal investigation was ongoing.*"<sup>17</sup>

- c. *"How Dr. Kent's ...insistence on hiring and promoting unqualified cardiothoracic surgeons—despite clear warnings from UVA's own search committees—set the stage for chaos in the department and poor outcomes for patients."*<sup>18</sup>
- d. *"How Dr. Kent's ...insistence on hiring and promoting unqualified cardiothoracic surgeons—despite clear warnings from Uva's own search committees -- set the stage for chaos in the department and poor outcomes for patients."*<sup>19</sup>
- e. *"In their interviews with Williams & Connolly's attorneys, several physicians described how, time and again, Dr. Kent and Dean Kibbe have hired whomever they wanted, even over the objections of their own search committees."*<sup>20</sup>
- f. ***"How Dr. Kent ignored the findings of Uva's own search committee, its quality officers, and its Credentials Committee when he hired Dr. Preventza, and thereafter, Dr. de la Cruz."***<sup>21</sup>
- g. *"Michael Ragosta, Chair of Uva's Credentials Committee, explained in his Williams & Connolly interview that the search committee 'categorized the candidates into three buckets... Dr. Preventza was in bucket three, the 'don't hire' bucket.' And yet, Dr. Kent and his leadership team decided to hire Dr. Preventza."*<sup>22</sup>
- h. ***"Kim de la Cruz hired despite warnings** Not long after Dr. Preventza became UVA's chief of cardiothoracic surgery, Dr. Kent and Dean Kibbe, along with chair of surgery Allan Tsung, worked with her to recruit Dr. Kim de la Cruz. And, just as they had done earlier with Dr. Preventza, Dr. Kent ... again bypassed their own search committee, dismissed other surgeons' concerns, and ignored their own quality officers' reports in order to hire him."*<sup>23</sup>
- i. *"Would other healthcare executives force the hire of an incompetent cardiac surgeon over the 'resounding objection' of their own search committee, continue to support her, and dismiss numerous staff warnings about how that surgeon was endangering patients? Would they make that surgeon chief of cardiothoracic surgery, and let her hire other surgeons? \* \* \* Dr. Kent ...have done all these things, which is why so many physicians have risked their careers to call for their resignation."*<sup>24</sup>

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<sup>17</sup> *Id.* at p. 3.

<sup>18</sup> *Id.* at p. 6.

<sup>19</sup> *Id.* at p. 9 (emphasis in original).

<sup>20</sup> *Id.* at p. 9.

<sup>21</sup> *Id.* (emphasis in original).

<sup>22</sup> *Id.* at p. 10.

<sup>23</sup> *Id.* at p. 12-13 (emphasis in original).

<sup>24</sup> *Id.* at p. 26.

70. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. Dr. Kent did not make the decision to hire Dr. Preventza or Dr. de la Cruz. Nor did he participate in, or direct, the search committee for either hire. In the case of Dr. Preventza, the decision to hire her was made by Dr. Allan Tsung (Department Chair of Surgery) and Dr. Chad Hoyt (chair of the search committee).

71. Recruitment of a division chief and or a faculty member was two and three levels below Dr. Kent's role as CEO of UVA Health. The Jones Law Firm Defendants could easily have found an organizational chart of UVA Health and known that Dr. Kent was not the hiring agent for a division chief or a faculty member. Moreover, the Jones Law Firm Defendants were aware that UVA health was a multibillion-dollar organization with multiple hospitals, two physician organizations, over a hundred clinics, a school of medicine (with 1,475 faculty) and a school of nursing. The notion that the CEO of this organization would be the decision maker regarding individual faculty recruitment defied common sense.

72. Moreover, it was the role of the Credentials Committee – a body made up of sixteen UVA Medical Center physicians – to investigate Dr. Preventza's credentials and prior experience, a process in which Dr. Kent played no role. The Credentials Committee determined that Dr. Preventza had the requisite background, relevant training, experience, and competence for the position. Indeed, she could not have been hired without such a determination.

73. The Clinical Staff Executive Committee (which also did not include Dr. Kent) thereafter reviewed the Credentials Committee's approval of Dr. Preventza's candidacy and formally voted to approve it. The Clinical Staff Executive Committee is comprised of approximately 37 members, whose duties include "control[ing] and monitor[ing] the memberships

of the Clinical Staff through oversight of the appointment, credentialing and privileging process.” That duty includes the review of the Credentials Committee report about candidates.

74. After the Credentials Committee and the Clinical Staff Executive Committee approved Dr. Preventza’s hire, the UVA Health System Board Committee approved the hiring by a vote in which Dr. Kent did not participate.

75. Thereafter, Dr. Preventza made the decision to hire Dr. de la Cruz after a national search, by a search committee in which Dr. Kent played no role. The Credentials Committee once again made the determination that the chosen candidate had the requisite background, relevant training, experience, and competence for the position. And once again, after both the Credentials Committee and the Clinical Staff Executive Committee approved Dr. de la Cruz’s candidacy, the UVA Health System Committee approved the decision to hire him by a vote in which Dr. Kent did not participate.

76. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements’ probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

77. Even a cursory investigation would have revealed that Drs. Preventza and de la Cruz could not have been hired absent approval of their “background, relevant training, experience and competency” by the Credentials Committee, and thereafter, approval of the Credentials

Committee's report by the Clinical Staff Executive Committee.<sup>25</sup> After that process, the UVA Health Board Committee had to approve the hires by vote of members, a vote in which Dr. Kent did not participate.

78. Given that the hiring process required three levels of approval, Dr. Kent could not have "hired" either candidate "over the objections of [his] own search committees," much less "forced" such hires.

79. The Jones Law Firm Defendants interviewed Dr. Tracci<sup>26</sup>, so they knew that the Credentials Committee and the Clinical Staff Executive Committee (of which Dr. Tracci was Chair) had approved the hires of Drs. Preventza and de la Cruz. Dr. Tracci was also present when the UVA Board Committee approved the hiring of Dr. de la Cruz by a unanimous vote (in which Dr. Kent did not participate).

80. Despite the fact that Dr. Kent was not on the search committee and had no role in its composition, the Jones Law Firm Defendants varyingly describe the search committee as "UVA's own search committee"<sup>27</sup>, "their own [Plaintiff's] search committee"<sup>28</sup>, "the search committee"<sup>29</sup>.

81. The Jones Law Firm Defendants' imprecision on this point was deliberate; they did not want the facts to get in the way of its false narrative. These facts are critical to the Letter Report's false statements that Plaintiff "insisted" and "force[d] the hire" of Dr. Preventza "over the objections of their own search committee," or "bypassed their own search committee."

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<sup>25</sup> See UVA Health Amended and Restated Bylaws of the Clinical Staff, p. 13, 50. Available at: <https://www.medicalcenter.virginia.edu/clinicalstaff/quick-links/clinical-staff-bylaws>. Accessed Feb. 22, 2026. Permanent link: <https://perma.cc/WH8P-RVWY>.

<sup>26</sup> See Ex. A, p. 13, fn. 95 (citing to "Megan Tracci interview with Jones Swanson").

<sup>27</sup> *Id.* at p. 9.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at p. 10.

82. The Letter Report also reveals no effort by the Jones Law Firm Defendants to speak to Dr. Hoyt, who chaired the search committee and recommended the hiring of Dr. Preventza. Nor did they make any attempt to interview Dr. Tsung, who made the decision to hire Dr. Preventza, or Dr. Preventza, who made the decision to hire Dr. de la Cruz. And, of course, they made no effort to interview Dr. Kent, the target of the statements.

83. Nor did the Jones Law Firm Defendants cite any communication from or to Dr. Kent showing either that he pushed that (or any other) hiring, or that *anybody* sent him an email, text or letter objecting to that (or any other) hiring. Nor did they cite, quote, or attach the supposed “quality officers reports” that Plaintiff supposedly ignored.<sup>30</sup>

84. As for Plaintiff “promoting” Dr. Preventza, such statements are likewise false, and the Jones Law Firm Defendants knew them to be false. Dr. Preventza was not promoted after her hiring, and the only “promotion” of Dr. Preventza referenced in the “report” is a footnote: “interview with Williams & Connolly re Dr. Preventza being touted by UVa at basketball halftime show. 2023-23 press releases and articles re Dr. Preventza”.<sup>31</sup> The “evidence” in the letter shows no connection with Dr. Kent.

- ***The false statements of purported fact that Dr. Kent mismanaged funds, which caused patients to go blind and suffer strokes.***

85. The Jones Law Firm Defendants repeatedly published in their Letter Report the statement that Dr. Kent mismanaged funds of the university, and that this mismanagement caused catastrophic health failures such as patients going blind and suffering:

- a. ***“In the five years since he started, Dr. Kent... has run UVa Health in a manner in which they have dismantled systems and protocols that were designed to ensure patient safety. Their failure to pay bills for essential supplies and services is ongoing. When their physicians warned Dr. Kent and his leadership that these changes were endangering patients, Dr. Kent ...e often dismissed their warnings***

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<sup>30</sup> *Id.* at p. 12-13.

<sup>31</sup> *Id.* at p. 3, fn. 13.

*and often, in return, disciplined them for not being 'team players.'*"<sup>32</sup> (Ex. A at p. 2; emphasis added).

- b. ***"How the mismanagement of funds by Dr. Kent ... has created an atmosphere of chaos and resulted in patients going blind, suffering strokes, and other catastrophic health failures."***<sup>33</sup>
- c. ***"How the mismanagement of funds by Dr. Kent... has created an atmosphere of chaos and resulted in UVa patients going blind, suffering strokes, and other catastrophic health failures."***<sup>34</sup>
- d. ***"One reason for the chaos at UVa Health is simply that Dr. Kent... ha[s] mismanaged UVa's money."***<sup>35</sup>

86. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable.

87. Dr. Kent was not directly involved in the manner in which vendors were paid, and the Letter Report cites no communication, act, or directive by Dr. Kent vendor invoices should not be paid.

88. Likewise, nothing in the Letter Report or any of the attached documents identify any instance in which Dr. Kent "dismantled systems and protocols that were designed to ensure patient safety."

89. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill

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<sup>32</sup> *Id.* at p. 2 (emphasis added).

<sup>33</sup> *Id.* at p. 6 (emphasis added).

<sup>34</sup> *Id.* at p. 16 (emphasis in original).

<sup>35</sup> *Id.* (emphasis added).

will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

90. The appalling statements by the Jones Law Firm Defendants – that Dr. Kent’s purported mismanagement of funds caused patients “going blind, suffering strokes, and other catastrophic health failures” – make for sensational headlines, but were false, which they knew or should have known.

91. The unfortunate incident resulting in a patient’s blindness in one eye was the result of a call center error, not unpaid invoices or a lack of medical supplies—which the Jones Law Firm Defendants knew. Their Letter Report itself acknowledges that “a patient went blind because the call center mishandled his triage” (but only in a section of the letter far removed to where the defamatory statements are made).<sup>36</sup>

92. The Jones Law Firm Defendants also knew, or recklessly ignored, that “UVA patients suffering strokes” likewise had nothing to do with unavailable medical supplies. Elsewhere in their Letter Report, they falsely attribute the strokes to Dr. Kent’s purported forced hire of allegedly incompetent doctors.<sup>37</sup>

93. Nowhere in the Letter Report is there any evidence of a patient safety issue tied to the lack of supplies.

94. The Jones Law Firm Defendants also knew, or recklessly ignored, the objective criteria that showed an improvement in patient care during Dr. Kent’s tenure. Over the five-year period of his tenure, UVA Health (as well as every other health system in the country) was evaluated externally for its ability to provide high quality care, using well-established metrics.

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<sup>36</sup> *See id.* at p. 18.

<sup>37</sup> *Id.* at p. 11-13.

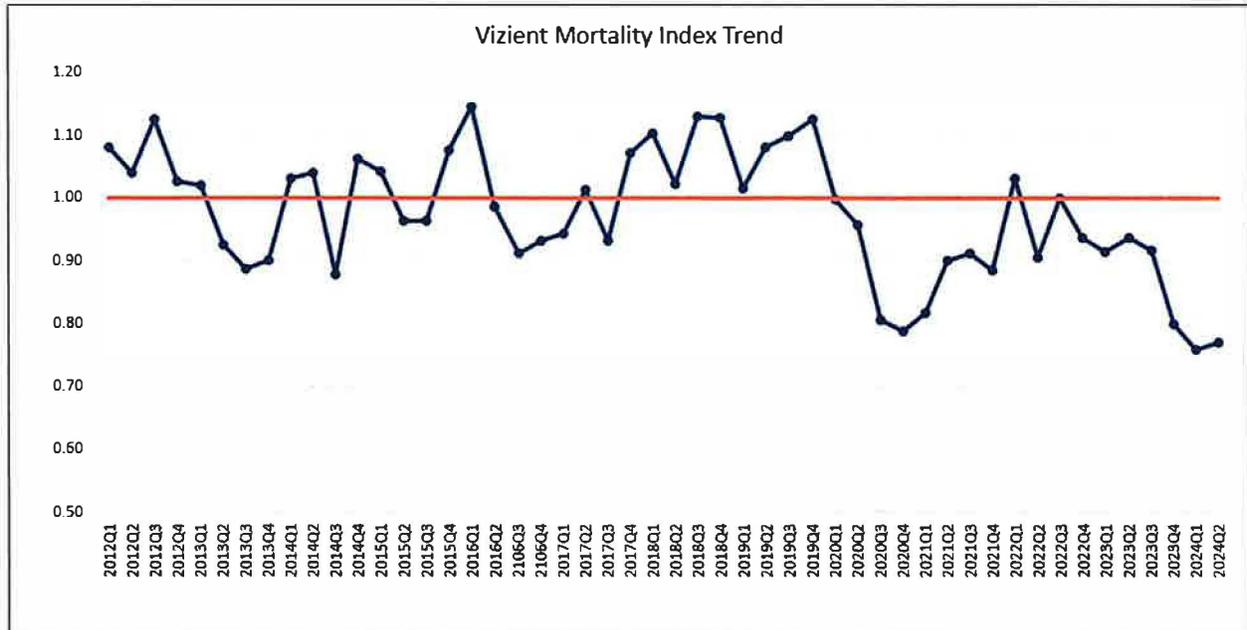
“Leapfrog” is one, which grades hospitals from A to F. In the fall of 2023 and the spring of 2024, all four UVA Health Hospitals achieved a grade “A” quality and safety status. Moreover, in December of 2023 UVA Health University Medical Center was awarded a TOP Teaching Hospital award by Leapfrog, which was celebrated throughout the organization.

95. Another well-trusted rating entity is Becker’s Healthcare. In 2024, it ranked UVA as once of the “top 30” most trusted health system brands nationally based on an online survey of over 26,000 households which received medical care in the prior two years. The Jones Law Firm Defendants knew this, unless they failed to review the public minutes of the UVA Health System Board.<sup>38</sup>

96. A second, key quality metric is the overall mortality achieved at the UVA Health University Medical Center. Mortality is measured by an external benchmarking organization called Vizient. The method of measurement is the use of a ratio of the actual number of deaths over the predicted number of deaths based upon data that stratifies the risk of hospitalized patients. A ratio greater than one demonstrates that more patients are dying than would be predicted, which is not the desired outcome. A value below one demonstrates that fewer patients are dying than would be expected. The diagram below demonstrates the risk adjusted mortality at UVA Medical Center over time:

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<sup>38</sup> See, e.g., June 6, 2024, Health System Board Minutes. Available at: <https://bov.virginia.edu/sites/g/files/jsddwu1171/files/2024-08/%2724%20JUN%20HSB%20MINUTES.pdf>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/MMD7-V5K9>.



This graph shows that prior to Dr. Kent’s arrival in 2020, the mortality at UVA Health Medical Center was very often significantly greater than one. After his arrival, the mortality consistently dropped below one (the desired outcome), and was .78 near the time of his departure, which is the lowest it had been over the previous ten years.

97. This information was routinely shared at UVA Health Board meetings as well at UVA Physician’s Group organization board meetings and included a “monthly score card.” “A good place to start is with the metrics you see on the monthly scorecard that our team assembles. These include the highest-level priorities of the organization, like mortality.... One of the most important uses for our data is to compare ourselves to our peer academic medical centers. For example, we’re able to see how our mortality rates compare to hospitals across the U.S.”<sup>39</sup> The

<sup>39</sup> *Data Helps Us Understand Our Performance*, UVA Vision and Voice, Sep. 19, 2022. Available at: <https://visionandvoice.uvahealth.com/2022/09/data-helps-us-understand-our-performance/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/LVQ9-J8S7>.

Jones Law Firm Defendants either knew about these objective metrics or turned a blind eye to them.

- ***The false statements of purported fact that Dr. Kent withheld resources from emergency room patients, which resulted in the inhumane treatment of thousands of patients.***

98. The Jones Law Firm Defendants repeatedly published in their Letter Report the statement that Dr. Kent withheld resources from emergency room patients, resulting in the inhumane treatment of thousands of patients:

- a. *“How Dr. Kent's decision to withhold resources from emergency room patients has resulted in the inhumane treatment of thousands of patients for the purpose of increasing revenues at UVa Health.”*<sup>40</sup>
- b. ***“How Dr. Kent's decision to withhold resources from emergency room patients has resulted in the inhumane treatment of thousands of patients for the purpose of increasing revenues at UVa Health.”***<sup>41</sup>
- c. *“As Dr. Ghaemmaghami and Dr. Enfield, vice chair for quality and patient safety for the Department of Medicine, discussed with Williams & Connolly, not only did Dr. Kent turn away COVID patients early in the pandemic, but he has subsequently used his Emergency Department to warehouse sick patients without spending the proper resources on them.”*<sup>42</sup>
- d. *“‘It's dangerous,’ Dr. Ghaemmaghami told Williams & Connolly. ‘He’s willing to put dozens of patients at risk every day by prolonging their wait time in the ER, because his imperative is to generate as much revenue as possible through surgeries.’”*<sup>43</sup>
- e. *“Dr. Kent has pursued a policy of increasing UVa’s emergency-department-to-emergency-department transfer patients—in short, to fill its emergency ward with as many patients as possible. As a result, UVa’s Emergency Department has become so crowded with sick patients, and those patients have to wait for such long periods of time, that each week hundreds of them decide to leave without even being seen by a doctor.”*<sup>44</sup>
- f. *“Meanwhile, sick patients wait side-by-side for hours in UVa’s emergency ward, even as Dr. Kent has ordered his staff to keep rooms and beds empty for high-dollar*

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<sup>40</sup> Ex. A at p. 6.

<sup>41</sup> *Id.* at p. 20 (emphasis in original).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at p. 21.

<sup>44</sup> *Id.*

*elective surgery patients—particularly neurology, cardiology, and oncology patients, which, as Dr. Enfield pointed out, ‘pay the most.’*”<sup>45</sup>

99. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements’ probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

100. The Medical Center Emergency Department reported to both the Chair of Emergency Medicine and the Chief Nursing Officer of the Medical Center. Thus, decisions regarding resource allocation for the Emergency Department and its management were made several levels below Dr. Kent. In any event, resources were not withheld from the emergency room at UVA Medical Center, and certainly not by Dr. Kent, and the letter points to no examples of that ever happening.

101. To the contrary, during Dr. Kent’s tenure, in June 2023, UVA Health Medical Center launched a major reorganization of its 80-bed Emergency Department. With the objectives of reducing wait times and providing the appropriate level of care for each patient, the Emergency Department trialed a number of improvements that were aptly named, “Excellence Driven.” With this work, the care of patients is divided into a number of smaller zones dedicated to various levels

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<sup>45</sup> *Id.*

of acuity. Extremely ill patients are taken to one area, moderately ill are treated in other zones, and less acute patients are treated in yet another unit. Patients that are not critically ill are allowed to sit in recliner chairs in their own clothes, as they wait for test results and may be managed without an IV. Research has shown that patients view these changes in flow quite positively. The project went into full implementation phase on July 6, 2023, and encouraging outcomes were found: a decrease in wait times to see the physician for all patients; a decrease in the rate of patients leaving because they have experienced long waits; already a decrease of one hour in the overall time spent by patients in the Emergency Department.

102. The Jones Law Firm Defendants either knew this or failed to investigate publicly available information about this important project.<sup>46</sup>

103. At the same time, Becker’s Hospital Review reported that emergency departments nationwide were experiencing high “volumes and growing wait times, patients are increasingly leaving emergency departments before completing treatment”.<sup>47</sup>

104. Finally, it is the role of the Clinical Staff Executive Committee to “monitor, oversee and, where appropriate, manage the quality of clinical care delivered within the Medical Center,” and “advise the Medical Center management regarding the allocation and distribution of clinical resources, including the assessment of beds, clinics, operating rooms, and other elements that are

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<sup>46</sup> See, e.g., Sep. 14, 2023, UVA Health System Board Meeting Minutes. Available at: <https://bov.virginia.edu/sites/g/files/jsddwul171/files/2023-10/%2723%20SEP%20HSB%20MINUTES.pdf>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/325H-TTYT>.

<sup>47</sup> Record number of patients leaving EDs without complete care, *Becker’s Hospital Review*, Aug. 14, 2023. Available at: <https://www.beckershospitalreview.com/care-coordination/record-number-of-patients-leaving-eds-without-complete-care/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/748F-V6HB>.

important to efficient and effective medical care within the Medical Center” and “make[ ] specific recommendations to the UVA HSB....”.<sup>48</sup>

105. At no time did Dr. Kent override or block any Emergency Department recommendation made to the UVA Health System Board by the Clinical Staff Executive Committee, nor could he have. The Jones Law Firm Defendants either knew these facts or failed to read the Clinical Staff Bylaws.

106. At best, the Jones Law Firm Defendants blindly relied on the allegations of the disgruntled doctors, without making an effort to interview Dr. Kent (who was the target of the allegations), which itself is reckless disregard whether the statements were true or false.

- ***The false statements of purported fact that Dr. Kent turned away patients during the COVID-19 pandemic.***

107. The Jones Law Firm Defendants published in their Letter Report the false claim or implication that Dr. Kent had given an order to turn away patients of COVID-19 during the early part of the pandemic:

- a. *“When the governor of Virginia lifted his ban on elective surgeries, according to Dr. Enfield, Dr. Kent ordered his staff to turn away Covid patients and prioritized the highest dollar procedures: cardiology, neurology, and oncology surgeries.”<sup>49</sup>*
- b. *“As Dr Ghaemmaghami and Dr. Enfield ... discussed with Williams & Connolly, not only did Dr. Kent turn away patients early in the pandemic....”<sup>50</sup>*

108. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the

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<sup>48</sup> UVA Health Amended and Restated Bylaws of the Clinical Staff, p. 50-51. Available at: <https://www.medicalcenter.virginia.edu/clinicalstaff/quick-links/clinical-staff-bylaws>. Accessed Feb. 22, 2026. Permanent link: <https://perma.cc/WH8P-RVWY>.

<sup>49</sup> Ex. A at p. 15.

<sup>50</sup> *Id.* at p. 20.

Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

109. Dr. Kent never issued such an order. To the contrary, under Dr. Kent's leadership, UVA Health devoted significant resources to the treatment of COVID patients, from the beginning of the pandemic to its end. In April 2020, the beginning of the crisis, UVA Health quickly retrofitted 56 of the 84 patient rooms in its new tower with negative airflow for the treatment of COVID patients.<sup>51</sup>

110. Also in 2020, UVA Health implemented clinical trials of four different COVID-19 therapies. To quote from a UVA Health news release, "Over the past nine months, clinical trials conducted at the University of Virginia have led to new treatments for patients fighting COVID-19 in Charlottesville and new tools for healthcare workers saving lives around the world."<sup>52</sup>

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<sup>51</sup> *Can We Really Do This? How UVA Health Transformed Its New Tower to Fight COVID*, UVA Today, May 7, 2020. Available at: <https://archive.news.virginia.edu/content/can-we-really-do-how-uva-health-transformed-its-new-tower-fight-covid/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/94A8-KCTG>.

<sup>52</sup> *Research that Saves Lives: Four COVID-19 Therapies Being Tested at UVA*, UVA Today, Dec. 11, 2020. Available at: <https://archive.news.virginia.edu/content/research-saves-lives-four-covid-19-therapies-being-tested-uva/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/4ZLC-A77X>.

111. The governor of Virginia lifted the ban on elective surgeries on May 1, 2020.<sup>53</sup> By July 2020, UVA Health was treating up to "17 [COVID] patients in the ICU..., and dozens more who don't meet ICU needs but are on the hospital wards receiving oxygen and other therapies."<sup>54</sup> Those numbers increased over time. For example, on January 27, 2022, 109 patients, including 8 children, were hospitalized at UVA Health with COVID.<sup>55</sup>

112. In an article published in the Charlottesville Daily Progress, July 25, 2020, Dr. Kent is quoted as saying "the university hospital has the ability to handle increased COVID cases, should a spike occur". He went on to state, "We have 700 beds at UVA, and we have multiple medical intensive care units. We have some units that are now closed and can be reopened, if needed. We are in a great position because we have the new tower that we opened just after (the) pandemic (began), and that has 84 beds, all of which are ICU compatible".

The Jones Law Firm Defendants either knew these facts, or deliberately failed to investigate public information about UVA Health's treatment of COVID patients throughout the pandemic. Nor did they ever find written proof of such an order, or seek to interview the UVA Medical Center CEO, much less Dr. Kent, to ascertain whether such an order was ever given. They willfully ignored conflicting evidence in pursuit of their agenda and the preconceived narrative about Dr. Kent's job performance on which their plan relied.

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<sup>53</sup> *Gov. Northam: Restrictions on elective surgeries will end tonight*, The Northern Virginia Daily, Apr. 30, 2020. Available at: [https://www.nvdaily.com/nvdaily/gov-northam-restrictions-on-elective-surgeries-will-end-tonight/article\\_653b5ba4-6998-5f97-8bfd-110df8a91df2.html](https://www.nvdaily.com/nvdaily/gov-northam-restrictions-on-elective-surgeries-will-end-tonight/article_653b5ba4-6998-5f97-8bfd-110df8a91df2.html). Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/2UWU-NHQJ>.

<sup>54</sup> *Q&A: From the Front Lines, Dr. Catherine Bonham Talks COVID-19*, UVA Today, Jul. 14, 2020. Available at: <https://archive.news.virginia.edu/content/qa-front-lines-dr-catherine-bonham-talks-covid-19/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/YK7V-AC34>.

<sup>55</sup> *UVA Health COVID Update: The Bottom Line for Jan. 27, 2022*, UVA HealthNews, Jan. 27, 2022. Available at: <https://www.uvahealth.com/healthy-balance/uva-health-covid-update-jan-27-2022/>. Accessed Feb. 21, 2026. Permanent link: <https://perma.cc/S3BL-2XHG>.

- ***The false statements of purported fact that Dr. Kent retaliated against physicians who questioned his policies.***

113. The Jones Law Firm Defendants repeatedly published in their Letter Report that Dr. Kent retaliated against physicians who questioned his policies:

- a. *“How Dr. Kent and Dean Kibbe retaliated against physicians who questioned their policies, even when their questions involved patient safety and protection for medical providers at UVa Health during COVID.”<sup>56</sup>*
- b. *“How Dr. Kent and Dean Kibbe retaliated against physicians who questioned their policies, even when their questions involved patient safety and protection for medical providers at UVa Health during COVID.”<sup>57</sup>*
- c. *“But when they have raised questions with Dr. Kent’s leadership team, Dr. Kent have responded by retaliating against them. This retaliation, in some cases, has been carefully coordinated.”<sup>58</sup>*
- d. *“Would other healthcare executives warn their own physicians not to sound the alarm about hospital conditions that had led to patients going blind, and surgical staff themselves having to be hospitalized? Dr. Kent ... ha[s] done all these things, which is why so many physicians have risked their careers to call for their resignation.”<sup>59</sup>*

114. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements’ probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with

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<sup>56</sup> Ex. A. at p. 6.

<sup>57</sup> *Id.* at p. 22.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.* at p. 26.

such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

115. There is no factual support for the statements as to Dr. Kent anywhere in the Letter Report.

116. Throughout their Letter Report, the Jones Law Firm Defendants repeat the mantra that Dr. Kent “retaliated against physicians who questioned their policies.” But Dr. Kent never terminated a single physician during his tenure; nor did he retaliate against anybody for any reason. The five “cases” cited in the Letter Report confirm this.

117. *Case #1: Dr. John Kern, Dr. Leora Yarboro, Dr. Nick Teman, Dr. Kenan Yount.*<sup>60</sup> They were held accountable by Dean Kibbe for being disrespectful to their leaders, culminating in the “letters of expectation,” letters that had nothing to do with “questioning the policies” of Dr. Kent. Moreover, Dr. Kent played no role in that letter. The Chair of Surgery, Dr. Yount’s direct report, made the decision to delay Dr. Yount’s promotion for a year, a decision in which Dr. Kent played no role. The Jones Law Firm Defendants either knew these facts or deliberately failed to interview the Chair of Surgery who made that decision.

118. *Case #2: Dr. Mark Roeser.*<sup>61</sup> Dr. Roeser was a pediatric heart surgeon at UVA Health. Complaints had been filed against him related to unprofessional behavior. At one point, Dr. Roeser was purportedly instructed to participate in an out-of-state rehabilitation program addressing physicians with issues relating to professionalism. To be promoted in the UVA School of Medicine, there is a requirement (as there is at most schools of medicine across the country) that the individual being promoted must have consistently demonstrated professional behavior. Dr.

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<sup>60</sup> *Id.* at p. 22.

<sup>61</sup> *Id.* at p. 23.

Roeser's promotion was delayed by the Department of Surgery in order to provide him the opportunity to improve his behavior. Dr. Kent was not aware of, nor did he play any role in, Dr. Roeser's disciplinary actions. Nor was Dr. Kent aware of the decision about Dr. Roeser's promotion. The Jones Law Firm Defendants either knew of Dr. Kent's lack of misconduct, or they deliberately failed to investigate by asking for documentary proof, or interviewing Dr. Kent.

119. *Case #3: Dr. Paul Yates.*<sup>62</sup> Dr. Yates had concerns regarding a patient call center error, resulting in a patient not receiving treatment that may have prevented blindness in one eye. When Dr. Yates brought this to the attention of medical center leadership, corrective action was immediately implemented. Dr. Yates was disciplined for unprofessional behavior by his Department Chair, following events in which Dr. Yates treated his colleagues in an unprofessional manner. After several failed requests of Dr. Yates to behave in a professional manner, he was formally disciplined by his Department Chair, with the support and collaboration of UVA Human Resources. The Department Chair made the decision to discipline Dr. Yates; Dr. Kent played no role.

120. *Case #4: Dr. Dana Albon.*<sup>63</sup> Dr. Albon was mistakenly proposed for promotion by the Department of Medicine before she was technically eligible. When the Department of Medicine and the Associate Dean of Faculty Affairs discovered this, the promotion process was not continued. Dr. Kent was not involved in any of these decisions. The Jones Law Firm Defendants either knew these facts or deliberately failed to ask Dr. Albon, much less Dr. Kent about them.

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<sup>62</sup> *Id.* at p. 24.

<sup>63</sup> *Id.* at p. 25.

121. *Case #5: Dr. Chris Kramer.*<sup>64</sup> Dr. Kramer is a respected researcher and cardiologist. In his role as co-director of the cardiovascular service line at UVA, he was responsible for patient access to cardiology care, clinical recruitment, as well as other aspects of the clinical operation. The metrics demonstrated that health system clinical goals in cardiology were not being met. Dr. Kramer's direct report, Chief Medical Officer and Director of Service Lines and the Chair of the Department of Medicine, decided to keep Dr. Kramer in his position as Division Chief, but to replace him in the role of Co-Service Lines Leader with Dr. Michael Valentine, with the goal of enhancing the clinical operation. This change in leadership was made for performance issues and had nothing to do with retaliation. The Jones Law Firm Defendants either knew these facts or deliberately failed to interview the involved leaders about why they made their decision.

- ***The false statement of purported fact that Dr. Kent was reported to have made “threats of retaliation” at OSU.***

122. The Jones Law Firm Defendants published in their Letter Report that Dr. Kent had engaged in threats of retaliation in his prior tenure at Ohio State:

*“Before Dr. Kent arrived at UVA, several news outlets had reported that physicians and faculty at his former institution, Ohio State, had sent not just one, but three no-confidence letters that called out Dr. Kent for the same kind of management practices he has displayed at UVA Health, including, tellingly, threats of retaliation.”*<sup>65</sup>

123. This statement of purported fact was of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. The Jones Law Firm Defendants also made this defamatory statement with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their

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<sup>64</sup> *Id.*

<sup>65</sup> *Id.* at p. 6.

truth or falsity. The Jones Law Firm Defendants also published the statement with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

124. None of the three sources cited as support for this statement state that any of the three no-compliance letters at OSU “called out Dr. Kent for... threats of retaliation.”<sup>66</sup>

125. The first cited article, in *The Lantern*, May 9, 2017, makes clear that the target of the “sharp criticism” of the letters was Dr. Sheldon Retchin, CEO of OSU’s Wexner Medical Center, who subsequently resigned. Nowhere does the article state that Dr. Kent had engaged in “threats of retaliation.”

126. The second cited article, in *The Columbus Dispatch*, March 6, 2017, mentions Dr. Retchin (the target of the letters) six times and Dr. Kent once: “The professors contend that Dr. Craig Kent, dean of the College of Medicine for seven months, has shown ‘an emerging pattern of leadership in the style promulgated by Dr. Retchin.’” While the article quotes the letter as stating “It is unfortunate that the Medical Center and College of Medicine leadership have created an environment of low morale, distrust, and retaliation,” nowhere does the article state that Dr. Kent had engaged in retaliation or “threats of retaliation.”

127. The third cited article, in *Cville Right Now*, September 23, 2024, states that a 2017 no-confidence letter was “aimed at OSU’s Wexner Medical Center CEO, Sheldon Retchin...” The article also stated that the letter “cited Kent, asserting that as Dean of the Medical College, he had adopted Retchin’s leadership style...” However, the article makes no mention of “retaliation”

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<sup>66</sup> *Id.* at p. 6, fn. 38.

by Dr. Kent, or that he engaged in “threats of retaliation.” The footnoted articles likewise do not offer any support to the statement that Dr. Kent engaged in “threats of retaliation at UVA Health.”

128. Given the Jones Law Firm Defendants’ search for negative information about Dr. Kent’s tenure at OSU, they undoubtedly discovered articles praising his leadership. In one, written seven months after Dr. Retchin’s resignation, the Board Chair of Wexner Medical Center, praised Dr. Kent’s leadership: “[He] talked about the med center’s improved oversight, thoughtful financial stewardship and lower-than-average turnover rates.... ‘I’m more excited today than I was a year ago or two years ago because we’re really doing better and better.’” The article goes on to say that “in response to what they heard, Kent and his team launched a review of clinical salaries resulting in raises for 600-700 underpaid clinicians”.<sup>67</sup> The Jones Law Firm Defendants did not mention such articles because they conflicted with the false narrative of “threats of retaliation.” In another article from The Ohio State University, it was stated: “In his three years as Dean of the Ohio State University College of Medicine, Dr. K. Craig Kent has welcomed dozens of high-profile recruits, accelerated the college’s steady growth in federal research funding, and lauded interdisciplinary clinical teams for their high-quality and differentiated patient care.”<sup>68</sup>

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<sup>67</sup> *Doctors Divided: Inside the power struggle at Ohio State’s medical center*, Columbus Monthly, Dec. 19, 2017. Available at: <https://www.columbusmonthly.com/story/lifestyle/2017/12/20/doctors-divided-inside-power-struggle/16797453007/>. Accessed Feb. 23, 2026. Permanent link: <https://perma.cc/6986-DVWR>.

<sup>68</sup> *Dr. Craig Kent Elected to National Academy of Medicine*, The Ohio State University Wexner Medical Center Press Release, Oct. 21, 2019. Available at: <https://wexnermedical.osu.edu/mediaroom/pressreleaselisting/kent-elected-to-national-academy-of-medicine>. Accessed Feb. 23, 2026. Permanent link: <https://perma.cc/XD8R-E6BP>.

- ***The false statements of purported fact that Dr. Kent engaged in race discrimination, HR complaints of discrimination, and HR policy violations.***

129. The Jones Law Firm Defendants published in their Letter Report that Dr. Kent had engaged in race discrimination, and related violations:

Senior faculty are aware of ***Dr. Kent's discriminatory hiring practices*** and his ***termination of team members without cause in violation of HR policies***. UPG recently lost its top candidate for the CAO position, ***an African American woman*** who was working in the Health System, when she chose to go elsewhere because of ***Dr. Kent's lack of support for Under Represented Minorities***. Faculty are also aware of ***several HR complaints against Dr. Kent for discrimination and bullying of team members***. Present and former senior members of UVA HR privately confide that they have seen ***obvious HR policy violations directed by Dr. Kent*** but that were ***bullied*** into executing them. At least two of these HR professionals resigned to avoid their own personal liability.<sup>69</sup>

130. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which the Jones Law Firm Defendants are liable. The Jones Law Firm Defendants also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. The Jones Law Firm Defendants also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

131. The statements are found in a letter that is unsigned, undated, and stamped "Draft." But the Jones Law Firm Defendants nonetheless published the document as a matter of fact.

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<sup>69</sup> Ex. A, App'x Doc. No. 17, p. 3 (emphasis added).

132. Worse, the statements were removed in the transmitted version of the letter, which the Jones Law Firm Defendants knew. In this regard, the Letter Report falsely states that the document is a draft letter from “October 2021.”<sup>70</sup> In fact, the document was a draft of a letter sent in September 2021. The Jones Law Firm Defendants knew this because they included in their Letter Report the September 2021 letter that was actually sent,<sup>71</sup> and its first paragraphs are nearly identical to the first paragraphs of the “Draft” letter.

133. The Letter Report also does not identify any “termination of team members without cause in violations of HR policies” by Dr. Kent because those terminations never happened. Nor does the Letter Report identify any “obvious HR policy violations directed by Dr. Kent” because those policy violations never happened, either.

134. The alleged acts of racial discrimination never happened, and there were no “HR complaints against Dr. Kent for discrimination and bullying of team members.” The Jones Law Firm Defendants knew that this statement was removed from the final version of the September 2021 letter. At a minimum, the Jones Law Firm Defendants published these statements with reckless disregard for their falsity.

#### **THE DEFAMATORY STATEMENTS TO THE PRESS IN THE WAKE OF THE OCTOBER 2025 LAWSUIT**

135. On October 3, 2025, a lawsuit was filed against Dr. Kent in the Western District of Virginia, which makes many of the same accusations as in the Letter Report and features Dr. Kent’s ouster as lending credence to them. Lead counsel for the plaintiffs are the Jones Law Firm Defendants and Defendant Bowers is local counsel.

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<sup>70</sup> Ex. A, p. 16-17, fn.126, 127, 129.

<sup>71</sup> Ex. A, App’x Doc No. 1.

136. Thereafter, Defendants Jones and Bowers began litigating their case in the press – outside the judicial proceedings – and defaming Dr. Kent in the process.

137. In various news articles, Jones and Bowers were quoted as making statements beyond the language of their complaint, including the false statements of purported fact that Dr. Kent was engaged in “criminal acts” and “illegal” and “unethical” practices, all related to billing fraud, including that he had implemented a Medicare “scam.” These statements were neither material to nor made in the course of a judicial proceeding.

138. In a press article dated on or about October 19, 2025, Bowers published the statement that the Kent administration had engaged in “illegal and unethical practices”:

*The claims made in the civil suit filed earlier this month mirror those Williams & Connolly investigated, according to MichieHamlett attorney Les Bowers. **Bowers said plaintiffs have waited months for the health system to take responsibility for the illegal and unethical practices of the Kent administration.** (See Exhibit B hereto).<sup>72</sup>*

139. In the same article, Defendant Jones published a statement echoing Bowers’ statement and adding that Dr. Kent had engaged in “illegal acts”:

*“What we can do under the law is bring a RICO action when there is an enterprise established to engage in criminal acts that damage and hurt people; and that’s what we’ve alleged here,” attorney Gladstone Jones of Jones Swanson Huddell told the Daily Progress. \* \* \* Jones said **Kent, Horton, Kibbe and others** named in the lawsuit **“were directly involved in the development of the strategy that included these illegal acts and caused these damages. And that’s why they were named and others were not.”**<sup>73</sup>*

140. In a press article dated on or about November 11, 2025, Bowers published the statement that Dr. Kent had implemented a “scam” of Medicare with a strategy of upcoding and double billing:

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<sup>72</sup> Ex. B at p. 5-7

<sup>73</sup> *Id.*

*And attorney Lee [sic] Bowers says UVA inflated bills for surgery by claiming two senior doctors were needed in the operating room for cases that were not that complicated.*

*“It leads to increasing revenue when there’s absolutely no need based on case complexity to have two attendings, but **it’s well-known that that is a way to scam Medicare.**” He adds that other fraudulent tactics were used to cut costs and boost the bottom line. “There are patients who had unnecessary procedures and people who went blind in the face of a year or more of warnings that this was going to happen if they continued to cut out the patient safety mechanisms in order to maximize financial goals.”*

\* \* \*

*“Anywhere that you could hire someone who would **implement the strategy of up-coding and double-billing**, that happened. Sixteen of 21 chairs were replaced, so we’re talking about completely wiping out all of UVA’s leadership in the space of four years so that Kent could install loyalists into those positions.”<sup>74</sup>*

141. These statements of purported fact were of and concerning Dr. Kent, false, and defamatory *per se*, for which Defendants Jones and Bowers are liable. They also made these defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements’ probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity. They also published the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

142. Among other things, Defendants Jones and Bowers knew, or should have known, that the Williams & Connolly investigation had found no evidence of billing fraud. Based on their extensive research into and review of the records available to them in preparing and filing the

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<sup>74</sup> See Ex. C at 2. Permanent link: <https://perma.cc/CG5F-DVQZ>.

federal lawsuit on October 3, 2025, Defendants Jones and Bowers were also aware that months earlier, on March 11, 2025, UVA publicly confirmed the finding of no billing fraud:

Coming out of the investigation, the Board and President [Jim] Ryan have determined that there is no basis for corrective action as it relates to health care billing or other regulatory compliance issues,” said UVA Rector Robert Hardie in a statement.<sup>75</sup>

143. No allegations of billing fraud survived the scrutiny of Williams & Connolly’s investigation and the internal review performed by UVA Health’s compliance team. No credible evidence of billing fraud existed at the time Defendants Jones and Bowers made their statements accusing Dr. Kent of participating in illegal billing acts, including up-coding, double-billing, and scamming Medicare.

### **COUNT I**

#### **Defamation *Per Se* Against All Defendants**

144. Plaintiff incorporates by reference Paragraphs 1-143 as if fully set forth herein.

145. Each of the statements of purported fact published by Defendants imputed an unfitness to perform or lack of integrity in Plaintiff’s performance of his job.

146. Each of the statements of purported fact published by Defendants necessarily prejudiced Plaintiff in his profession.

147. The statements of purported fact published by Defendants Jones and Bowers concerning billing fraud, illegal and criminal conduct accuse Plaintiff of committing serious crimes: felonies punishable by imprisonment.

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<sup>75</sup> *Investigation won’t lead to big changes at UVA Health*, CBS 19 News. Available at: [https://www.cbs19news.com/news/investigation-wont-lead-to-big-changes-at-uva-health/article\\_92822526-fee1-11ef-bcaf-7b847d82c5e7.html](https://www.cbs19news.com/news/investigation-wont-lead-to-big-changes-at-uva-health/article_92822526-fee1-11ef-bcaf-7b847d82c5e7.html). Accessed Feb. 20, 2026. Permanent link: <https://perma.cc/L3LT-QZ7A>.

148. Each of the defamatory statements published by Defendants are statements of purported fact, capable of being proven true or false, and false.

149. Defendants published each of the defamatory statements with actual malice. Prior to and at the time the Defendants made their defamatory statements, they knew the statements were false, had a high degree of awareness of the statements' probable falsity, and/or entertained serious doubts as to the truth of the statements, and so proceeded to publish the statements with reckless disregard for their truth or falsity.

150. The accounts in the Letter Report and press would have been implausible to the Defendants because they attributed acts to Dr. Kent that were far divorced from his job duties, including but not limited to making individual care decisions for individual patients, and hiring decisions that were multiple levels below his role. Dr. Kent was CEO of a large multibillion dollar health system with multiple hospitals, physician organizations, hundreds of clinics, a school of medicine, and a school of nursing. Yet, the Letter Report alleges Dr. Kent's direct involvement everywhere: hiring individual surgeons, in an ophthalmology clinic working with schedulers, retaliating against individual doctors (many whom he had never met), involved in the credentialing of physicians, or directly managing a transfer center and deciding which patients would be accepted, or directly managing the resources of one of the health systems four emergency rooms.

151. Defendants also published each of the statements with common law malice, in that they acted from personal spite or ill will, with sinister or corrupt motives, or with such gross indifference and recklessness as to amount to a wanton or willful disregard of the rights of Dr. Kent.

152. As a result of Defendants' acts, Dr. Kent is entitled to compensation for the monumental injuries he suffered to his business and personal reputations, for his humiliation,

emotional and mental anguish, and embarrassment, as well as for pecuniary losses (including millions of dollars in lost employment opportunities), and punitive damages.

## **COUNT II**

### **Tortious Interference with Contract Against The Jones Law Firm Defendants**

153. Plaintiff incorporates by reference Paragraphs 1-152 as if fully set forth herein.

154. In December 2023, Dr. Kent and UVA entered into an extension of his employment contract through February 1, 2030. Dr. Kent's contract, as extended, included \$1.6 million in base annual salary and a bonus structure and deferred compensation component representing another \$500,000 in annual earnings.

155. The Jones Law Firm Defendants knew of Dr. Kent's contract extension.

156. The Jones Law Firm Defendants induced or caused UVA to breach Dr. Kent's contract. Through the publication of their Letter Report to each member of the UVA Board of Visitors, the Jones Law Firm Defendants intentionally caused a termination of that contract through their demand that UVA President Jim Ryan force an immediate resignation by Dr. Kent or otherwise terminate him.

157. The Jones Law Firm Defendants achieved that intended, primary purpose through improper means or methods, including the publication of defamatory statements and other unethical conduct, such a deceptively wording and timing their Letter Report to resemble work product of UVA's official investigation conducted by Williams & Connolly.

158. Dr. Kent has been damaged by that interference. His contract was terminated five years before its scheduled expiration, and the Jones Law Firm Defendants' wrongful conduct has precluded him from finding comparable employment in his field.

**WHEREFORE**, Plaintiff moves the Court for the entry of a judgment against these Defendants in the following amounts:

a. Against each of the Jones Law Firm Defendants (Jones Swanson Huddell LLC, Gladstone Jones, and Lynn Swanson), jointly and severally, the amount of Thirty-Two Million Dollars (\$32,000,000.00), for presumed damages and actual damages for harm and injury to Plaintiff's reputation arising from their defamatory publication of the Letter Report on February 24, 2025;

b. Against Defendant Gladstone Jones, the amount of One Million Dollars (\$1,000,000.00), for presumed damages and actual damages for harm and injury to Plaintiff's reputation arising from his defamatory publications of November 11, 2025;

c. Against Defendant Les Bowers, the amount of One Million Dollars (\$1,000,000.00), for presumed damages and actual damages for harm and injury to Plaintiff's reputation arising from his defamatory publications of October 19, 2025, and November 11, 2025;

d. Against each of the Jones Law Firm Defendants (Jones Swanson Huddell LLC, Gladstone Jones, and Lynn Swanson), jointly and severally, the amount of Seven Million, Three Hundred Thousand Dollars (\$7,300,000.00), for compensatory damages arising from tortious interference with Plaintiff's employment agreement;

e. Against each of the Defendants, jointly and severally, the amount Three Hundred and Fifty Thousand Dollars (\$350,000.00) for punitive damages arising from conduct reflecting a willful or wanton and reckless disregard for Plaintiff's rights.

f. Prejudgment interest from the date of the alleged tortious conduct, pursuant to Va. Code § 8.01-382; and

g. Such other and further relief as the Court deems appropriate.

**TRIAL BY JURY IS DEMANDED.**

Respectfully submitted,

**DR. K. CRAIG KENT**

*By Counsel*

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**From:** Gladstone Jones <[GJones@joneswanson.com](mailto:GJones@joneswanson.com)>

**Sent:** Monday, February 24, 2025 10:24 AM

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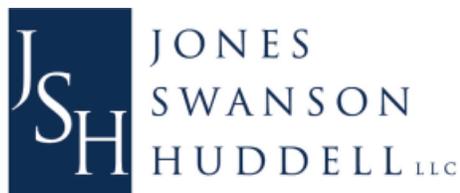
**Subject:** University of Virginia Doctors' Report for the Board of Visitors Board Meeting to be held on February 25, 2025 and Appendix

Dear University of Virginia Board of Visitors' Members and Counsel,

In anticipation of the University of Virginia Board of Visitors meeting on Tuesday, February 25, 2025 regarding the University of Virginia Faculty Letter of No Confidence in Craig Kent and Melina Kibbe submitted on September 5, 2024, please find a report from the doctors who were assisted in this investigation by Jones Swanson Huddell LLC, and an Appendix, attaching all of the documents referenced therein.

With best regards,

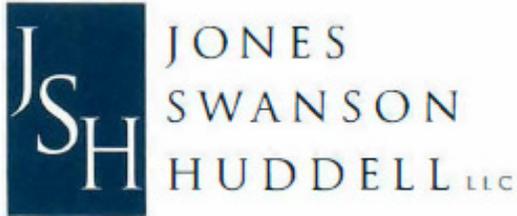
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February 24, 2025

VIA ELECTRONIC MAIL ONLY

**The Board of Visitors of the University of Virginia  
Williams & Connolly**

**RE: UNIVERSITY OF VIRGINIA DOCTORS' REPORT FOR THE BOARD OF  
VISITORS BOARD MEETING TO BE HELD ON FEBRUARY 25, 2025**

### **Introduction**

Between February 2020 when Dr. Craig Kent began working at UVa Health, through September of 2024, multiple reports were made to President James Ryan, Provost Ian Baucom, and others at the pinnacle of UVa leadership that Dr. Kent and Dean Melina Kibbe were employing practices and exercising policies and procedures in such ways that harm was being caused directly to the patients of UVa Health. On September 5, 2024, after four years of trying, and failing, to work within UVa's system to draw attention to these patient safety issues, 128 UVa Physicians Group-employed faculty signed a letter of no confidence in Craig Kent and Melina Kibbe, calling for their immediate removal “out of urgent concern for our patients, community, and the University of Virginia.”

Soon thereafter, UVa's Board of Visitors hired the law firm of Williams & Connolly LLP to undertake an investigation into the claims asserted by the faculty in the letter of no confidence in Dr. Kent and Dean Kibbe. It is presumed that approximately 100 interviews have been conducted to date by Williams & Connolly. Jones Swanson Huddell LLC assisted 35 doctors and one UVa Physicians Group board member who provided information and documentation to Williams & Connolly in the context of these interviews.

The following report represents the testimony of those 36 participants. They are presenting this report both as an account of their experiences under Dr. Kent's administration at UVa and also as a reflection of the interview process they've been carrying out for five months now with attorneys from Williams & Connolly LLP. During those five months, these physicians have revealed the facts as they know them.

The physicians whose testimony appears here also offer to recount the following facts in person to the Board of Visitors.

## Executive Summary

In February 2020, when Craig Kent became executive vice president in charge of UVa Health, he immediately made it clear that he intended to impose his own will there regardless of Virginia law, UVa policies, orders from the governor of Virginia—or even the safety of UVa's patients.

Early in his tenure, Dr. Kent appointed Wendy Horton, his personal choice for CEO, without consulting his faculty or considering any other candidates for the job.<sup>1</sup> He cut staff salaries during the first wave of COVID, then declined to repay his staff with federal funds he'd received for that very purpose.<sup>2</sup> He also found creative ways to circumvent the governor of Virginia's emergency health orders related to the pandemic.<sup>3</sup> According to Kyle Enfield, vice chair for quality and patient safety for the Department of Medicine, Dr. Kent ordered his staff to turn away COVID patients on the pretext that they did not have the resources to treat them; meanwhile, he also ordered his staff to keep rooms and beds empty in anticipation of the eventual return of high-dollar elective surgeries.<sup>4</sup>

In the five years since he started, Dr. Kent, together with his dean of the School of Medicine, Melina Kibbe, has run UVa Health in a manner in which they have dismantled systems and protocols that were designed to ensure patient safety.<sup>5</sup> Their failure to pay bills for essential supplies and services is ongoing.<sup>6</sup> When their physicians warned Dr. Kent and his leadership that these changes were endangering patients, Dr. Kent and Dean Kibbe often dismissed their warnings and often, in return, disciplined them for not being "team players."<sup>7</sup>

It has been Dr. Kent's hiring strategy, and Dean Kibbe's implementation of that strategy, however, that has caused the most distress among UVa physicians and the most harm to UVa patients. Time and again, Dr. Kent and Dean Kibbe have dismissed UVa policy and the findings

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<sup>1</sup> Va. Code Ann. § 23.1-1303(17), governing boards of public institutions of higher education in Virginia, reads “the governing board of each public institution of higher education shall...[s]olicit the input of representatives of the institution's faculty senate or its equivalent ... (ii) in advance of decisions to be made on the search for the institution's new chief executive officer.” Chair of the UVa Physicians Group Julie Speasmaker wrote to President Ryan that hiring a CEO without consulting faculty or considering other candidates was “something that as far as we know has never been done before.” Julie Speasmaker interview with Williams & Connolly (“W&C”); UPG September 2021 letter of no confidence that begins “We are here today as fiduciaries...”.

<sup>2</sup> Tracey Hoke, Julie Speasmaker interviews with W&C; UPG September 2021 letter of no confidence that begins “We are here today as fiduciaries...;” See also:

<https://budget.lis.virginia.gov/amendment/2022/1/HB30/introduced/CA/486/18h/>

<sup>3</sup> Kyle Enfield interview with W&C.

<sup>4</sup> Robert Powers interview with W&C.

<sup>5</sup> Paul Yates, Nina Solenski, Bobby Chhabra, John Kern interviews with W&C.

<sup>6</sup> Emails regarding credit holds and outstanding invoices from Cordis, Phillips, and Boston Scientific (including spreadsheet listing outstanding invoices).

<sup>7</sup> Chris Ghaemmaghami interview with Jones Swanson; Dana Albon, Carol Manning, Nick Teman interviews with W&C.

of their own protocol-established search committees, in order to force the hire of their own, hand-picked choices.<sup>8</sup> Worse, once they've chosen their candidates, they have tried to control any due diligence about them by warning other physicians to support their choices, whether or not they agreed with them.<sup>9</sup> And when these new physicians have shirked their duties, or proved to be unqualified, Dr. Kent and Dean Kibbe have not only turned a blind eye to these problems, but retaliated against other physicians who reported the risk they presented to patients.<sup>10</sup>

Dr. Kent and Dean Kibbe have repeated this pattern in multiple departments, but it's in the Division of Cardiothoracic Surgery where their hiring strategies have, so far, had the most disastrous results for UVa Health's patients.<sup>11</sup>

In the fall of 2024, UVa's Credentials Committee initiated an investigation of multiple questionable patient outcomes associated with two cardiac surgeons that Dr. Kent and Dean Kibbe had hired and championed throughout the past year. They continued to promote these surgeons not only through their hiring process, but even after UVa residents, senior surgeons, nurses, quality officers, and Credentials Committee members had warned that these surgeons had exhibited bizarre behaviors in the operating room and put patients' lives in "grave risk."<sup>12</sup> Indeed, they continued to promote at least one of these physicians publicly as one of UVa's best, at the time an internal investigation was ongoing.<sup>13</sup>

In the midst of the Credential Committee's investigation, as well as this investigation by Williams & Connolly, UVa has quietly and suddenly sidelined both of these cardiac surgeons.

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<sup>8</sup> Jay Gangemi, John Kern, Michael Ragosta, Angela Taylor, Nick Teman, Megan Tracci, Leora Yarboro, Kenan Yount (cardiology and cardiothoracic surgery) interviews with W&C, Laurie Brenner, Carol Manning, Nina Solenski (neurology) interviews with W&C, Amy Bouton (microbiology immunology and cancer biology), Chris Ghaemmahami (dean of the school of medicine, chief medical officer) interviews with W&C. *See* Tracey Hoke interview with W&C in which she explains that Dean Kibbe thinks, in hiring, that one shouldn't involve any faculty for whom the hire would be a boss. Dr. Hoke disagrees: "in these small worlds, if you don't involve your team in the search process, you take away one of your ways to access information about a candidate."

<sup>9</sup> Angela Taylor interview with W&C (re Allan Tsung's claim that Dr. Kent said there could not be a failed search), Megan Tracci interview with W&C (re her questions to Dr. Kent about due diligence and Dr. Kent's response that he would consider it to be her fault if Dr. de la Cruz's hire did not go forward). Michael Ragosta interview with W&C re Dr. Kent falsely accusing the Credentials Committee of "not doing its job" to give Preventza various privileges. In his interview with W&C, Bobby Chhabra notes, "Never in the past would the leadership interfere in hiring" and referenced how such interference takes away from "the sanctity of hiring and credentialing." Bobby Chhabra interview with W&C.

<sup>10</sup> John Kern, Kenan Yount, Mark Roeser, Nick Teman interviews with W&C.

<sup>11</sup> John Kern, Kenan Yount, Mark Roeser, Nick Teman, Angela Taylor, Megan Tracci, Tracey Hoke interviews with W&C.

<sup>12</sup> Angela Taylor letter to the Credentials Committee, in the possession of Williams & Connolly.

<sup>13</sup> James Gangemi interview with W&C re Dr. Preventza being touted by UVa at basketball halftime show. 2023-'24 press releases and internet articles re Dr. Preventza.

Additionally, Williams & Connolly attorneys have heard from Dr. Trey Lee, a world-class pediatric oncologist who was recruited to UVa in 2016 to continue working on his "paradigm changing" bone marrow treatment for children.<sup>14</sup> As Dr. Lee knows better than almost anyone, bone marrow transplants are extraordinarily high-risk procedures.<sup>15</sup> They require precise equipment and, most importantly, a specially trained staff.<sup>16</sup>

Once Dr. Kent arrived at UVa, he stopped providing Dr. Lee with the staff and equipment he needed—and yet, Dr. Kent has continued to pressure Dr. Lee to go forward with a procedure under circumstances that Dr. Lee has described as tantamount to malpractice, and that could, conceivably, be deadly for a child patient.<sup>17</sup> It is this situation, Dr. Lee says, that caused him to reach out to Williams & Connolly, so that he could alert them to the dangerous situation in which Dr. Kent is putting child patients if Dr. Lee were not there to stand in his way.<sup>18</sup>

Today, after five years of Dr Kent's administration, it is not surprising that UVa has lost many of its physicians, who have decided to leave UVa and take jobs elsewhere. One of the first to depart was Chief Medical Officer and Interim CEO Chris Ghaemmaghmi, who in April 2020 sent UVa President James Ryan a letter explaining why he could not, in good conscience, continue to work with Dr. Kent.<sup>19</sup> "I have spent years working to improve safety, quality, and value of care for our patients in the Charlottesville community and throughout the Commonwealth," he wrote.<sup>20</sup> "[Dr. Kent] is focused on increasing revenues through surgical care and seems disinterested in exactly how we achieve this financial success."<sup>21</sup>

Dr. Ghaemmaghmi has participated in Williams & Connolly's investigation, where he's made the same point more bluntly. "I had the sense that, if I remained on the team, you'd be investigating me now."<sup>22</sup>

Additionally, senior faculty members who spoke up for their fellow physicians have been stripped of their leadership positions.<sup>23</sup> Dr. Kent's treatment of Dr. Bobby Chhabra is a case in point. Dr. Chhabra arrived at UVa after medical school and has remained on Grounds for 34 years.<sup>24</sup> He has been a full professor since 2008 and the Orthopedics Department's chair since 2013. He has served on the School of Medicine Board for twelve years and served on the Health

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<sup>14</sup> Trey Lee interview with W&C.

<sup>15</sup> Trey Lee interview with W&C.

<sup>16</sup> Trey Lee interview with W&C.

<sup>17</sup> Trey Lee interview with W&C.

<sup>18</sup> Trey Lee interview with W&C.

<sup>19</sup> Chris Ghaemmaghmi interview with W&C. Dr. Ghaemmaghmi left UVa in December 2022.

<sup>20</sup> Chris Ghaemmaghmi letter to President James Ryan, April 7, 2020.

<sup>21</sup> Chris Ghaemmaghmi letter to President James Ryan, April 7, 2020.

<sup>22</sup> Chris Ghaemmaghmi interview with W&C.

<sup>23</sup> See Chris Kramer, Bobby Chhabra interviews with W&C.

<sup>24</sup> Bobby Chhabra interview with W&C.

System Board for seven years. He served as the UVa Physician's Group President for many years, thereby ensuring that the voices of the physicians he represented would be elevated in leadership.<sup>25</sup> Dr. Chhabra has served in almost every leadership position available to him at UVa and has received many of its awards.<sup>26</sup> He also designed, oversaw construction, and directs UVa's busy Orthopedic Center, which is widely considered a model for other healthcare institutions across the US. And yet, in their very first meeting, when Dr. Chhabra offered his support and advice, Dr. Kent rebuffed him.<sup>27</sup> Soon afterward, Dr. Kent ordered Dr. Chhabra to step down as President of the UVa Physician's Group, and threatened to take away his directorship of his own Orthopedic Center and his position as Chair of Orthopaedics if he didn't do so.<sup>28</sup> Even after Dr. Chhabra complied, he said, Dr. Kent stripped him of other leadership roles, thus undermining the votes of the various boards on which Dr. Chhabra held a position.<sup>29</sup>

"I hope you'll understand that this is the truth. These are facts," Dr. Chhabra told Williams & Connolly.<sup>30</sup> "This is the worst morale I have seen at this institution in 34 years...We don't have proper staff or equipment. You have to beg for support...They hire the wrong people, and they don't vet the people that they do hire."<sup>31</sup>

In September of 2024, 128 physicians signed a letter of no confidence in Dr. Kent and Dean Kibbe and sent it to UVa's rector and Board of Visitors.<sup>32</sup> It was an extraordinary act, and yet it was hardly the first time that Dr. Kent's own physicians had warned university leadership about him. In April, 2020, Dr. Ghaemmaghami described his concerns about Dr. Kent's leadership in his resignation letter to President Ryan.<sup>33</sup> In October, 2021, the Public Directors for the Board of UVa Physicians Group sent President Ryan a letter and then met with him to explain, in specific detail, the reasons they had "lost confidence in Dr. Kent's ability to lead UVA Health."<sup>34</sup> On January 9, 2024, the Faculty Senate raised concerns about Dr. Kent's administration to Provost Ian Baucom, who relayed them to President Ryan the following day.<sup>35</sup> On August 14, 2024, Dr. Robert Powers wrote a letter to President Ryan regarding "Health System Leadership and the current environment at the UVa Medical Center."<sup>36</sup> On that same day

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<sup>25</sup> Bobby Chhabra interview with W&C.

<sup>26</sup> Bobby Chhabra interview with W&C.

<sup>27</sup> Bobby Chhabra interview with W&C.

<sup>28</sup> Bobby Chhabra interview with W&C.

<sup>29</sup> Bobby Chhabra interview with W&C.

<sup>30</sup> Bobby Chhabra interview with W&C.

<sup>31</sup> Bobby Chhabra interview with W&C.

<sup>32</sup> UVa Faculty letter of no confidence in Craig Kent and Melina Kibbe, September 5, 2024.

<sup>33</sup> Chris Ghaemmaghami letter to President James Ryan, April 7, 2020,. Chris Ghaemmaghami interview with W&C.

<sup>34</sup> Bobby Chhabra, Julie Speasmaker interviews with W&C; UPG September 2021 letter of no confidence that begins "We are here today as fiduciaries...;" Bobby Chhabra told Williams & Connolly that he, as President of the UPG, met with Julie Speasmaker to "outline the problems seen at the time," including many that were included in the more recent September 2024 letter of no confidence.

<sup>35</sup> Faculty Senate Resolution on One Team United Access and Culture.

<sup>36</sup> Letter from Robert Powers to President James Ryan, August 14, 2024.

in August of 2024, a group of faculty leaders from across the medical school met with President Ryan and advised him to relieve Dr. Kent of his duties.<sup>37</sup>

Before Dr. Kent arrived at UVa, several news outlets had reported that physicians and faculty at his former institution, Ohio State, had sent not just one, but three no-confidence letters that called out Dr. Kent for the same kind of management practices he has displayed at UVa Health, including, tellingly, threats of retaliation.<sup>38</sup>

This report focuses on six of Dr. Kent's and Dean Kibbe's leadership and management practices and the impacts thereof at UVa Health:

1. How Dr. Kent has repeatedly pressured a pediatric oncologist to conduct unsafe procedures on children with cancer.
2. How Dr. Kent's and Dean Kibbe's insistence on hiring and promoting unqualified cardiothoracic surgeons—despite clear warnings from UVa's own search committees—set the stage for chaos in the department and poor outcomes for patients.
3. How, during a nationwide COVID emergency, Dr. Kent undercut his own physicians and staff as they battled the pandemic and protected the Commonwealth by developing COVID testing and protocols.
4. How the mismanagement of funds by Dr. Kent, Dean Kibbe, and Wendy Horton has created an atmosphere of chaos and resulted in patients going blind, suffering strokes, and other catastrophic health failures.
5. How Dr. Kent's decision to withhold resources from emergency room patients has resulted in the inhumane treatment of thousands of patients for the purpose of increasing revenues at UVa Health.
6. How Dr. Kent and Dean Kibbe retaliated against physicians who questioned their policies, even when their questions involved patient safety and protection for medical providers at UVa Health during COVID.

**1. How Dr. Kent has repeatedly pressured a pediatric oncologist to conduct unsafe procedures on children with cancer.**

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<sup>37</sup> Kenan Yount, Stephen Culp interviews with Jones Swanson and W&C.

<sup>38</sup> "Wexner Medical Center CEO Steps Down amid Questions of Leadership," *The Lantern*, May 9, 2017. "Faculty Letter Expresses 'No Confidence' in OSU Wexner Medical Center CEO," *The Columbus Dispatch*, May 6, 2017. "UVA's Not the First No Confidence Letter for Craig Kent," *Cville Right Now*, September 23, 2024.

In 2015, before Dr. Kent started his tenure at UVa, the university aggressively recruited and then hired Dr. Trey Lee, a world-class pediatric hematology and oncology researcher, and a member of the National Institutes of Health team that developed the first manufacturing platform for the Car T-cell.<sup>39</sup> According to Dr. Lee, this work was “paradigm changing”: it established a new class of treatment for relapsed leukemia and lymphoma, and led to doctors like himself “taking kids who had no other options after a leukemia relapse and completely curing their leukemia forever.”<sup>40</sup>

Today, Dr. Lee is the only pediatric hematologist and oncologist at UVa and, in fact, in the Commonwealth of Virginia.<sup>41</sup> He is also the sole bone marrow and stem cell transplant provider in the Department of Pediatrics at UVa, and he oversees all of UVa's inpatient pediatric oncology patients.<sup>42</sup>

***Dr. Kent has failed to provide Dr. Lee with the specialized staff he needs to perform a transplant***

As Dr. Lee explained to Williams & Connolly, a pediatric bone marrow transplant is an “incredibly high risk” procedure, in part because it temporarily knocks out a child's immune system.<sup>43</sup> “The process that has to happen from referral to follow-up is massive,” Dr. Lee explained, and it requires a “very, very specialized” staff.<sup>44</sup> “You can't take people who've never done this and ask them to figure it out,” Dr. Lee said.<sup>45</sup>

According to UVa's own consultant, Dr. Lee's program must include at least two dedicated transplant physicians, at least two specially trained primary care providers, specially trained nurses, dedicated pharmacists, specially trained dietary, social services and physical therapy staff, a marrow collection director, a marrow collection staff member, apheresis staff, and a dedicated scheduling person.<sup>46</sup>

When UVa hired Dr. Lee, it committed to providing him with this specialized staff.<sup>47</sup> But none of these positions is currently filled, and Dr. Kent has resisted filling them, instead telling

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<sup>39</sup> Trey Lee interview with W&C.

<sup>40</sup> Trey Lee interview with W&C.

<sup>41</sup> Trey Lee interview with W&C.

<sup>42</sup> Trey Lee interview with W&C.

<sup>43</sup> Trey Lee interview with W&C.

<sup>44</sup> Trey Lee interview with W&C.

<sup>45</sup> Trey Lee interview with W&C.

<sup>46</sup> FACT Consulting Services Consultation Report for UVa Medical Center Children's Hospital titled *Development of Pediatric Hematopoietic Cell Transplant and Immune Effector Cell (IEC) Program and Integration with UV Health System Adult HVT and IEC Program*, February 8, 2021.

<sup>47</sup> Memorandum of Understanding attached to Dr. Trey Lee's offer of employment; Trey Lee interview with Jones Swanson.

Dr. Lee that he has not yet provided enough "return on investment," and that he'll give him the staff he needs only "when you've done a few more transplants."<sup>48</sup>

As Dr. Lee pointed out to Williams & Connolly, this puts him in a "Catch-22. The message is 'Do this. I know it requires all these things you don't have, but do it anyway.'"<sup>49</sup>

Dr. Lee is not the only one whom Dr. Kent has put in this Catch-22. Last summer, three of UVa's pediatric oncology doctors left the institution because they were "frustrated by the lack of resources" there, he said.<sup>50</sup> One of them was a doctor whom Dr. Lee had recruited from Charlotte Children's Hospital who left because "he was incredibly frustrated about the lack of resources for the program" and he was "pushed to do transplants anyway."<sup>51</sup> Another, Dr. Lee noted, was showing clear signs of "moral distress" because "he was pressured to deliver things he could not because he didn't have the resources."<sup>52</sup>

***Dr. Kent's constant pressure to perform unsafe bone marrow transplants on children***

Meanwhile, Dr. Lee said, Dr. Kent has repeatedly pressured him to go ahead with transplants using staff who don't have the required training. In an email to his department chair, Madhusmita Misra, Dr. Lee explained that he had "been told time and time again that we have the people in place and I can just use them."<sup>53</sup> Since the three oncologists left over the summer, he told Williams & Connolly, Dr. Kent has actually pushed him to go ahead and perform a transplant on a child as the sole physician. "That is absolutely out of bounds," Dr. Lee said.<sup>54</sup> "It would be medical malpractice to take a transplant case with only me on board."<sup>55</sup>

Dr. Kent has also asserted pressure on Dr. Lee's supervisors. Mike Engel, Dr. Lee's division chief, wrote to him in June 2023 that his program was "under considerable scrutiny...The health system leadership team seems willing to make abrupt changes when programs to which they have committed resources are underperforming...I have heard it mentioned that some have suggested pulling the plug on pediatric transplant."<sup>56</sup> "Dr. Kent is asking about any possible patients," wrote Dr. Misra, in an email to Dr. Lee in March 2024.<sup>57</sup> She

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<sup>48</sup> Trey Lee interview with W&C.

<sup>49</sup> Trey Lee interview with W&C.

<sup>50</sup> Trey Lee interview with W&C.

<sup>51</sup> Trey Lee interview with W&C.

<sup>52</sup> Trey Lee interview with W&C.

<sup>53</sup> Email exchange between Dr. Lee and his chair, Madhusmita Misra re: *Pedi SCTCT program requirements*, March 27-28, 2024.

<sup>54</sup> Trey Lee interview with W&C.

<sup>55</sup> Trey Lee interview with W&C.

<sup>56</sup> Michael Engel email exchange with Trey Lee and Philip Roehrs, re: *transplant progress.....*, June 13, 2023.

<sup>57</sup> Email between Dr. Lee's chair, Madhusmita Misra, and Dr. Lee re: *Pedi SCTCT program requirements*, March 28, 2024.

also told him that, "at the beginning of every chairs' meeting, the first question Dr. Kent always asks is 'when are you going to start doing these transplants?'"<sup>58</sup>

### ***A barrier to protect children***

Near the end of his interview, Williams & Connolly asked Dr. Lee how he would respond to the allegation that he, Dr. Lee, was actually the barrier to doing more marrow transplants and moving his program forward.<sup>59</sup>

"I'd embrace that," he responded. "I'd be proud to be the barrier to malpractice and doing unsafe things to patients."<sup>60</sup>

Then he reported that he'd lately been worrying that, if he left, Dr. Kent "would replace me with a new trainee who wouldn't know...his own limitations. Part of medicine," Dr. Lee said, "is knowing your limitations and knowing when to ask for help."<sup>61</sup> He described how he worried that "harm will come to these kids" if he—the only barrier to Dr. Kent's insistence of conducting an unsafe marrow transplant on a child—were taken down.<sup>62</sup>

"That keeps me up at night," Dr. Lee provided.<sup>63</sup>

## **2. How Dr. Kent's and Dean Kibbe's insistence on hiring and promoting unqualified cardiothoracic surgeons—despite clear warnings from UVa's own search committees—set the stage for chaos in the department and poor outcomes for patients.**

In their interviews with Williams & Connolly's attorneys, several physicians described how, time and again, Dr. Kent and Dean Kibbe have hired whomever they wanted, even over the objections of their own search committees.<sup>64</sup>

That is exactly what Dr. Kent and Dean Kibbe did in the case of Ourania Preventza, and later, Kim de la Cruz, in the department of cardiothoracic surgery.

### ***How Dr. Kent ignored the findings of UVa's own search committee, its quality officers, and its Credentials Committee when he hired Dr. Preventza, and thereafter, Dr. de la Cruz***

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<sup>58</sup> Trey Lee interview with W&C.

<sup>59</sup> Trey Lee interview with W&C.

<sup>60</sup> Trey Lee interview with W&C.

<sup>61</sup> Trey Lee interview with W&C.

<sup>62</sup> Trey Lee interview with W&C.

<sup>63</sup> Trey Lee interview with W&C.

<sup>64</sup> Bobby Chhabra told Williams & Connolly that he refuses to sit on any search committee anymore because when you "provide five possible [hires] and they hire number 15, you can see there is no use participating." Bobby Chhabra interview with W&C.

In January 2023, UVa Health was looking for a new chief of cardiothoracic surgery, and Ourania Preventza was one of the candidates.

UVa's search committee unanimously recommended **not** to hire Dr. Preventza.<sup>65</sup>

Michael Ragosta, Chair of UVa's Credentials Committee, explained in his Williams & Connolly interview that the search committee "categorized the candidates into three buckets...Dr. Preventza was in bucket three, the 'don't hire' bucket."<sup>66</sup>

And yet, Dr. Kent and his leadership team decided to hire Dr. Preventza.<sup>67</sup>

Angela Taylor, UVa's lead quality officer for heart and vascular services, was concerned when she learned Dr. Preventza had been chosen.<sup>68</sup> She said people had been calling from Baylor, Dr. Preventza's former institution, to warn that she was "not capable of operating alone."<sup>69</sup> Dr. Taylor reached out to Chair of Surgery Allan Tsung and recommended that they treat this round of hiring as a "failed search...that there were quality concerns" about Dr. Preventza "from a lot of people, and that they should start looking again."<sup>70</sup> But, she said, Dr. Tsung told her that was impossible, as Dr. Kent had insisted that they could not have a failed search.<sup>71</sup>

On March 28, 2023, UVa announced that Dr. Preventza had been hired as its chief of cardiothoracic surgery. She assumed that role on June 19, 2023.<sup>72</sup>

***How Dean Kibbe dismissed early warnings about Dr. Preventza from surgeons, residents, and a "special review" committee***

Dr. Preventza started conducting surgeries in October 2023. Within three weeks, according to Dr. John Kern, a renowned cardiovascular surgeon with 37 years of experience, a group of residents came to him with "concerns about her competence."<sup>73</sup> According to Jolian Dahl, one of the chief residents running the cardiac surgery service, Dr. Preventza was "asking them to do steps of operations that they hadn't done before because the attending physician

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<sup>65</sup> Michael Ragosta interview with W&C.

<sup>66</sup> Michael Ragosta interview with W&C.

<sup>67</sup> Angela Taylor interview with W&C; letter to Credentials Committee, in the possession of Williams & Connolly; Megan Tracci, Michael Ragosta interviews with W&C.

<sup>68</sup> Angela Taylor interview with W&C; Angela Taylor timeline; letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>69</sup> Angela Taylor interview with W&C.

<sup>70</sup> Angela Taylor interview with W&C; Angela Taylor timeline; Megan Tracci, Michael Ragosta interviews with W&C.

<sup>71</sup> Angela Taylor interview with W&C; Angela Taylor timeline; Megan Tracci, Michael Ragosta interviews with W&C.

<sup>72</sup> UVa School of Medicine Announcement welcoming Ourania Preventza as new chief of cardiothoracic surgery.

<sup>73</sup> John Kern interview with W&C.

hadn't gotten to teach that particular step yet."<sup>74</sup> Dr. Yount confirmed that he had observed Dr. Preventza improperly trying to hand off critical surgical maneuvers to residents.<sup>75</sup> Residents who worked with her were reporting "moral distress."<sup>76</sup>

Of urgent concern both to residents as well as to other cardiac surgeons were Dr. Preventza's cross-clamp times in surgery, which were sometimes nearly twice as long as they should have been, and which put her patients at a higher risk of suffering a stroke.<sup>77</sup>

Eventually, the residents' complaints regarding Dr. Preventza made their way to Brad Kesser, who was the associate designated institutional officer for all graduate medical education (residency) training at UVA. In March 2024, he put together a team to conduct a "special review" of Dr. Preventza's interactions with residents.<sup>78</sup> Among their findings were two startling orders that Dr. Taylor, in her role as quality officer, later wrote about to the UVA's Credentials Committee, as to two patients facing dire patient outcomes. Williams & Connolly has the report from Dr. Taylor.

While these investigations proceeded, Dean Kibbe directly warned several cardiac surgeons that, if they didn't embrace Dr. Preventza's leadership, it would affect their own careers.<sup>79</sup> Dr. Kern received a disciplinary letter from Dean Kibbe when he and several other doctors walked out of a meeting in which they felt Dr. Preventza was lying about a patient safety issue.<sup>80</sup> Dr. Yount also left, and he also received a disciplinary letter from Dean Kibbe, as did Dr. Yarboro and Dr. Teman, another surgeon who was only attending the meeting remotely.<sup>81</sup> Dr. Yount, the most junior of these doctors, was later told that, because of this letter, he would be denied promotion.<sup>82</sup> Outgoing Health System Board Chair Babur Lateef expressed outrage over Dean Kibbe's discipline of these doctors, and asked John Kosky, vice president and chief human

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<sup>74</sup> Jolian Dahl interview with W&C. In addition to the residents' concerns about Dr. Preventza's competence, Dahl told W&C that they also reported Dr. Preventza's "unprofessional behavior in a leadership setting" and related multiple instances of her bullying the residents.

<sup>75</sup> Kenan Yount, Leora Yarboro, Angela Taylor interviews with W&C. Dr. Yount told Jones Swanson that he also observed that Dr. Preventza had difficulty troubleshooting basic cardiopulmonary bypass. Tracey Hoke reported that the residents were complaining that, in the operating room, Dr. Preventza was not directing them appropriately, and that she was unable to "progress a case." Tracey Hoke interview with W&C.

<sup>76</sup> *Special Review of Thoracic Surgery-Independent/Integrated Residency Program*; Brad Kesser interview with W&C.

<sup>77</sup> Kenan Yount, Angela Taylor interviews with W&C.

<sup>78</sup> Brad Kesser interview with W&C; *Special Review of Thoracic Surgery-Independent/Integrated Residency Program*.

<sup>79</sup> John Kern interview with Jones Swanson.

<sup>80</sup> John Kern interviews with W&C, Jones Swanson. Kenan Yount interview with W&C.

<sup>81</sup> Nick Teman interview with W&C. It is worth noting that at least one of these surgeons left to start their day in the operating room, a point ignored by leadership.

<sup>82</sup> Kenan Yount interview with W&C.

resources officer, to investigate the situation. Following the investigation, Dr. Yount's disciplinary letter was removed from his human resources file.<sup>83</sup>

### *Dr. Preventza's Surgeries*

In her interview with Williams & Connolly, Dr. Angela Taylor explained how, as UVa's lead quality officer for heart and vascular services, she has a unique position. "Everyone," she said, "comes to me when they have problems."<sup>84</sup>

Dr. Taylor received an increasingly long list of complaints about Dr. Preventza's surgeries, which she forwarded up the chain of command to Dr. Kent and his leadership team.<sup>85</sup> However, as Dr. Taylor informed Williams & Connolly, "with Preventza...information gets buried."<sup>86</sup> Dr. Taylor decided to take the information regarding patient impact to UVa's Credentials Committee.<sup>87</sup>

On November 8, 2024, Dr. Taylor presented to the Credentials Committee a letter detailing 13 specific cases in which Dr. Preventza was associated with patient endangerment.<sup>88</sup>

According to Dr. Taylor, after reviewing her letter regarding Dr. Preventza, the Credentials Committee voted to proceed with an investigation of Dr. Preventza.<sup>89</sup> However, in what Dr. Taylor described to Williams & Connolly as an "unprecedented" event, Dr. Preventza negotiated her resignation with UVa leadership and the investigation into patient outcomes by the Credentials Committee was never completed.<sup>90</sup>

### *Kim de la Cruz hired despite warnings*

Not long after Dr. Preventza became UVa's chief of cardiothoracic surgery, Dr. Kent and Dean Kibbe, along with chair of surgery Allan Tsung, worked with her to recruit Dr. Kim de la Cruz.<sup>91</sup> And, just as they had done earlier with Dr. Preventza, Dr. Kent and Dean Kibbe again

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<sup>83</sup> Kenan Yount interview with W&C.

<sup>84</sup> Angela Taylor interview with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>85</sup> Angela Taylor interview with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>86</sup> Angela Taylor interview with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>87</sup> Angela Taylor interview with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>88</sup> Angela Taylor interviews with W&C and Jones Swanson.

<sup>89</sup> Angela Taylor interview with Jones Swanson.

<sup>90</sup> Angela Taylor interview with Jones Swanson.

<sup>91</sup> Megan Tracci interview with W&C.

bypassed their own search committee, dismissed other surgeons' concerns, and ignored their own quality officers' reports in order to hire him.

Before Dr. de la Cruz was hired, Dr. Taylor, in her role as quality officer, received disturbing reports about him, including that his former institution had not allowed him to do surgeries by himself.<sup>92</sup> "Everyone knew these concerns," she told Williams & Connolly.<sup>93</sup> She pointed out that Dr. Kern, Dr. Ragosta, and Dr. Mike Valentine had reported them to Dr. Tsung, who, as chief of surgery, was working directly with Dr. Kent, Dean Kibbe, and Dr. Preventza on hiring Dr. de la Cruz.<sup>94</sup> "It was known by counsel and leadership that these groups had concerns, but were counseled that they must rely on information submitted by the department and could not look into concerns independently."<sup>95</sup>

Nevertheless, Dr. de la Cruz's candidacy proceeded.

Megan Tracci, President of UVa's Clinical Staff, was also watching Dr. de la Cruz's hiring process, and she also became concerned.<sup>96</sup> As Dr. Tracci explained to Williams & Connolly, she eventually became concerned enough to reach out to UVa counsel and ask if they had any other options before finalizing the hire of Dr. de la Cruz.<sup>97</sup> When she raised the issue of due diligence, Dr. Kent interjected and made it clear that if there was any problem with Dr. de la Cruz's hire then he would treat it as a lack of due diligence by and the fault of her own committee, the Clinical Staff Committee, as well as the Credentials Committee.<sup>98</sup> Dr. Tracci said that it was "unprecedented for the Executive Vice President to weigh in personally on initial credentialing and privileging."<sup>99</sup>

On June 4, 2024, UVa announced its hire of Dr. de la Cruz to co-lead its aortic program.<sup>100</sup> Just over five months later, after a meeting at which an unfortunate patient outcome was discussed, Dr. de la Cruz left the Medical Center and has not returned to work.

During his five-month tenure at UVa, Dr. de la Cruz was involved in at least three notable surgery events.<sup>101</sup> In one of those events, an emergency patient arrived at the hospital with a condition that was purportedly Dr. de la Cruz's specialty. But Dr. de la Cruz refused to

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<sup>92</sup> Angela Taylor interview with W&C.

<sup>93</sup> Angela Taylor interview with W&C.

<sup>94</sup> Angela Taylor interview with W&C.

<sup>95</sup> Megan Tracci interview with Jones Swanson.

<sup>96</sup> Megan Tracci interview with W&C.

<sup>97</sup> Angela Taylor interview with W&C; Angela Taylor timeline; Megan Tracci, Michael Ragosta interviews with W&C.

<sup>98</sup> Megan Tracci Interview with W&C.

<sup>99</sup> Megan Tracci interview with Jones Swanson.

<sup>100</sup> Behzad Farivar interview with W&C; "Kim Insua de la Cruz, MD, is Associate Professor Surgery at University of Virginia (UVa) School of Medicine, and Co-Director of the Aortic Disease Program at UVa Health."

<https://uvahealth.com/findadoctor/Kim-de%20la%20Cruz-1902059447>.

<sup>101</sup> Angela Taylor, Jay Gangemi, Mark Roeser interviews with W&C.

perform the surgery, called it a "prohibitive risk" and instead, recommended a palliative care consultation.<sup>102</sup> Fortunately, two other vascular surgeons, Dr. Tracci and Dr. Behzad Farivar, co-director of UVa's aortic center, were also on hand that night, and they not only disagreed with Dr. de la Cruz's assessment but conducted the surgery he had declined to perform.<sup>103</sup> Thirty days later, the patient walked out of the hospital.<sup>104</sup>

### **3. How, during a nationwide COVID emergency, Dr. Kent undercut his own physicians and staff as they battled the pandemic and protected the Commonwealth by developing COVID testing and protocols.**

Dr. Kent started in his position at UVa less than two weeks after the US government had declared a nationwide public health emergency regarding COVID-19.<sup>105</sup> It was a time of tumult at UVa Health, where physicians and staff were scrambling to prepare for the coming pandemic.<sup>106</sup>

Dr. Enfield, who was in charge of UVa's intensive care units at the time, reached out for advice from colleagues in Italy, where the virus had already had a profound impact.<sup>107</sup> Based on advice from his Italian colleagues as well as lessons he'd learned while studying the Ebola virus, Dr. Enfield converted patient rooms to negative pressure in order to help prevent the spread of the virus.<sup>108</sup>

Amy Mathers, associate director of clinical microbiology, was not only rushing to learn what she could about this new virus but also taking on many of UVa's burgeoning practical problems like its shortage of swabs, the inevitable furloughing of employees, and announcements to care-givers that they had to work without masks.<sup>109</sup> Early in the pandemic, as UVa physicians called for COVID tests with greater and greater urgency, Dr. Mathers decided to develop COVID testing and protocols herself.<sup>110</sup>

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<sup>102</sup> See redacted patient record, page 2 of 3.

<sup>103</sup> See redacted patient record, page 2 of 3.

<sup>104</sup> Behzad Farivar interview with W&C.

<sup>105</sup> Amy Mathers, Chris Ghaemmaghami, Julie Speasmaker interviews with W&C. Dr. Kent began at UVa on February 1, 2020 (<https://news.virginia.edu/content/dr-craig-kent-appointed-uva-executive-vice-president-health-affairs>). The US Dept. of Health and Human Services declared a nationwide public health emergency on January 31, 2020. "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," Trump White House Archives, <https://trumpwhitehouse.archives.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-COVID-19-outbreak/>.

<sup>106</sup> Kyle Enfield, Amy Mathers interviews with W&C.

<sup>107</sup> Kyle Enfield interview with W&C.

<sup>108</sup> Kyle Enfield interview with Jones Swanson.

<sup>109</sup> Amy Mathers interview with W&C.

<sup>110</sup> Amy Mathers interview with W&C.

Dr. Ghaemmaghmi, meanwhile, was making complex and difficult decisions about what elective treatments to cancel and what transfer requests to eliminate.<sup>111</sup> He was also communicating to his 8,000 reports, many of whom were frightened, as the media had widely reported the news about bodies stacked in trucks outside hospitals in other cities.<sup>112</sup>

Dr. Kent responded to all of this activity, at first, by taking a vacation.<sup>113</sup> When he returned a couple of weeks later, he changed the systems Dr. Enfield, Dr. Mathers, and Dr. Ghaemmaghmi had been successfully employing to prepare for the pandemic. Then Dr. Kent banned all decision-making that did not include himself.<sup>114</sup>

Meanwhile, as Dr. Ghaemmaghmi pointed out in his 2020 letter to President Ryan, Dr. Kent's primary concern during this time seemed to be keeping UVa open for high-cost elective surgeries.<sup>115</sup> When the governor of Virginia lifted his ban on elective surgeries, according to Dr. Enfield, Dr. Kent ordered his staff to turn away COVID patients and prioritize the highest-dollar procedures: cardiology, neurology, and oncology surgeries.<sup>116</sup>

Then there was the issue of testing, which Dr. Mathers had taken responsibility for since early on in the pandemic.<sup>117</sup> According to Dr. Mathers, in March 2020, the Commonwealth of Virginia had roughly 80 tests for eight million people, and yet, in spite of this scarcity, Dr. Kent directed her to test himself, his family members, and other VIPs, and to record the results in fake medical records.<sup>118</sup>

To make matters worse, according to Dr. Kramer, chief of the division of cardiology, "leadership was slow-walking pre-operative testing " so that, for months, his staff was unnecessarily getting exposed to COVID and their patients were being put at risk.<sup>119</sup> In October of 2020, when Dr. Kramer tried to organize department heads to push for more pre-operative COVID testing for patients after a mass COVID exposure resulted in multiple quarantine events and the closure of the Coronary Care Unit,<sup>120</sup> he says he was told to "stop rabblousing."<sup>121</sup>

In the midst of all this, according to Tracey Hoke, UVa Health's chief of quality and performance improvement, Dr. Kent offered his employees the choice to take either a 20% pay

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<sup>111</sup> Chris Ghaemmaghmi interview with W&C.

<sup>112</sup> Chris Ghaemmaghmi interview with W&C.

<sup>113</sup> Chris Ghaemmaghmi, letter to President James Ryan, April 7, 2020.

<sup>114</sup> Kyle Enfield interview with W&C.

<sup>115</sup> Chris Ghaemmaghmi interview with W&C.

<sup>116</sup> Kyle Enfield interview with W&C.

<sup>117</sup> Kyle Enfield interview with W&C.

<sup>118</sup> Amy Mathers interview with W&C.

<sup>119</sup> Chris Kramer interview with W&C.

<sup>120</sup> Chris Kramer email dated October 27, 2020.

<sup>121</sup> Chris Kramer interview with W&C.

cut for a three-month period or a two-week furlough from their employment at UVa.<sup>122</sup> And although UVa later received federal funds for pandemic-related reimbursements, the employees who had risked their lives and sacrificed their paychecks during the pandemic were never reimbursed.<sup>123</sup>

**4. How the mismanagement of funds by Dr. Kent, Dean Kibbe, and Wendy Horton has created an atmosphere of chaos and resulted in UVa patients going blind, suffering strokes, and other catastrophic health failures.**

As Williams & Connolly attorneys have heard repeatedly in their interviews with physicians, UVa Health has become a fearful, disorienting place to work under Dr. Kent's administration.<sup>124</sup> Part of this is his unprofessional manner—the threatening, the unpredictable behavior, such as when he ordered Bobby Chhabra, chair of the Department of Orthopaedic Surgery at UVa, to give up his leadership positions if he wanted to keep the orthopedic center he had designed, negotiated financing for, and fought to build for 10 years.<sup>125</sup>

One reason for the chaos at UVa Health is simply that Dr. Kent, Dean Kibbe, and Ms. Horton have mismanaged UVa's money.<sup>126</sup> Throughout Julie Speasmaker's tenure as chairman of the Board of the UVa Physicians Group, she questioned Dr. Kent and President Ryan about the financial stability of UVa Health, highlighting the lack of a strategic plan, the nonexistent transparency with regard to the allocation of costs between the Health System and UPG, and inquiring about the financial implications of the purchase of the three northern Virginia hospitals.<sup>127</sup>

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<sup>122</sup> Tracey Hoke, Julie Speasmaker interviews with W&C. On the same day the employee cuts were announced, the 'Initial Response to Fiscal Impact of COVID-19 was published, announcing that the senior leadership team would take a 10% salary reduction. See "UVA Outlines Initial Response to Fiscal Impact of Covid-19," *UVAToday*, April 14, 2020 (<https://news.virginia.edu/content/uva-outlines-initial-response-fiscal-impact-COVID-19>).

<sup>123</sup> Tracey Hoke interview with W&C. See also: <https://budget.lis.virginia.gov/amendment/2022/1/HB30/introduced/CA/486/18h/>.

<sup>124</sup> Dana Albon, Stephen Culp, Kyle Enfield, Trey Lee, Carol Manning, Amy Mathers, Nina Solenski, Angela Taylor, Megan Tracci, Seth Yarboro, Jeff Young interviews with W&C; Darrin Clouse, Kyle Enfield, Behzad Farivar, Trey Lee interviews with Jones Swanson.

<sup>125</sup> Bobby Chhabra, Jay Gangemi, Chris Ghaemmaghami, Julie Speasmaker, Kenan Yount interviews with W&C; Julie Speasmaker interviews with Jones Swanson.

<sup>126</sup> June 2020 letter to Kent that begins "As the Public Directors, we represent...;" letter written in June of 2021 that begins "We would like to better understand...;" UPG September 2021 letter of no confidence that begins "We are here today as fiduciaries...;" October 2021 draft letter that begins "We are here today as concerned fiduciaries..." letter to Public Directors that begins "I want to tell you...;" and a letter to President Ryan that begins "Thank you for taking the time to meet with us today."

<sup>127</sup> Julie Speasmaker interview with W&C; June 2020 letter to Kent that begins "As the Public Directors, we represent...;" letter written in June of 2021 that begins "We would like to better understand...;" UPG September 2021 letter of no confidence that begins "We are here today as fiduciaries...;" October 2021 draft letter that begins "We are here today as concerned fiduciaries..." letter to Public Directors that begins "I want to tell you...;" and a letter to President Ryan that begins "Thank you for taking the time to meet with us today."

Likewise, Dr. Angela Taylor brought to her interview with Williams & Connolly records indicating that UVa isn't paying its bills.<sup>128</sup> Meanwhile, physicians and nurses throughout UVa Health have struggled to deal with staff and resource shortages, malfunctioning equipment, and how crucial systems keep getting dismantled by management.<sup>129</sup>

### *Neurology*

Dr. Nina Solenski, a neurologist specializing in cerebrovascular disease, wanted to make sure she participated in this investigation, she said, because all this chaos under Dr. Kent is affecting patient safety.<sup>130</sup>

"You walk into a room and there are no compression socks, no bags, not enough nurses," Dr. Solenski said. "Everywhere you turn, there seems to be the perception that we're doing things by the seat of our pants. That's really frightening."<sup>131</sup>

Of particular concern to Dr. Solenski is the way that UVa now doesn't have enough radiologists, and films are often outsourced. "When you're reading films of a brain, you want the best," she said, but now she is never sure whether her films are being read by trained neuroradiologists.<sup>132</sup> She pointed out that a number of readings have been missed, including a recent mistake that had resulted in a patient suffering a stroke.<sup>133</sup>

"This is a systemic problem," she told Williams & Connolly. "It's not just within the department of neurology."<sup>134</sup>

### *Cardiology*

Indeed, the radiology problems Dr. Solenski has encountered are not limited to UVa's department of neurology. In September of 2024, cardiothoracic surgeon John Kern was asked to consult on a life-threatening missed diagnosis on a CT scan done at UVa's medical center. Dr. Kern easily recognized the missed diagnosis himself when reviewing the CT scans, and when he

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<sup>128</sup> Emails regarding credit holds and outstanding invoices from Cordis, Phillips, and Boston Scientific (including spreadsheet listing outstanding invoices).

<sup>129</sup> June 2020 letter to Kent that begins "As the Public Directors, we represent...;" letter written in June of 2021 that begins "We would like to better understand...;" UPG September 2021 letter of no confidence that begins "We are here today as fiduciaries...;" October 2021 draft letter that begins "We are here today as concerned fiduciaries..." letter to Public Directors that begins "I want to tell you...;" and a letter to President Ryan that begins "Thank you for taking the time to meet with us today." John Kern, Mark Roeser, Nina Solenski, Julie Speasmaker, Megan Tracci, Paul Yates interviews with W&C; Paul Yates emails.

<sup>130</sup> Nina Solenski interview with W&C.

<sup>131</sup> Nina Solenski interview with W&C. Bobby Chhabra also commented on the state of affairs at the Medical Center. "The main operating rooms are the worst places to work. We don't have staff or equipment. You have to beg for support." Bobby Chhabra interview with W&C.

<sup>132</sup> Nina Solenski interview with W&C.

<sup>133</sup> Nina Solenski interview with W&C.

<sup>134</sup> Nina Solenski interview with W&C.

asked the attending cardiologist why the diagnosis was missed, Dr. Kern was informed that the cardiologist had asked the radiologist the same thing and was told “we don’t have enough radiologists to read the volume of studies we do, so we contract some studies out.”<sup>135</sup>

### *Ophthalmology*

Starting in late 2020, ophthalmologist Paul Yates was worried about UVa Health's new "patient friendly access system."<sup>136</sup> It wasn't just the fact that it was new—technological change is a normal part of medicine—but rather that the people answering his patients' calls didn't know what to do when his patients called in.<sup>137</sup> His former staff had been expert in ophthalmology triage, he said, and they could handle calls as well or better than some of the doctors themselves.<sup>138</sup> But now leadership had taken away his staff, and the "patient friendly access system" kept making mistakes in urgent patient situations.<sup>139</sup>

On February 10, 2021, after the call center's mistakes had caused several near-disasters for patients, Dr. Yates reached out to CEO Wendy Horton to directly alert leadership about these urgent patient-safety issues:

I apologize for intruding into your day, but this issue is not being resolved working through lower channels and it is of I believe an urgent nature...Anyone who knows me as well as the other providers in our department knows that patient safety and satisfaction is of paramount concern. I would not be raising this to your level if it were not for that...I am hopeful that you can step in here and please address this immediately.<sup>140</sup>

Ms. Horton promised to deal with the matter right away, he said—but nothing happened.<sup>141</sup> Then, after struggling to get management to address this problem, Dr. Yates's worst fear came to pass: a patient went blind because the call center had mishandled his triage. "The plane has finally crashed," he wrote in an email that he sent to his fellow ophthalmologists, the

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<sup>135</sup> John Kern interview with Jones Swanson.

<sup>136</sup> Paul Yates interview with W&C; email dated January 26, 2021 at 2:19 p.m. from Dr. Yates to Dr. Shildkrot, copying many others, re: *Two monocular patients mismanaged by call center*.

<sup>137</sup> Paul Yates interview with W&C; email dated January 26, 2021 at 10:37 a.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Krishi Peddada, Yevgeniy Shildkrot, and Alice Shang; email dated January 26, 2021 at 1:51 p.m. from Dr. Shildkrot.

<sup>138</sup> Paul Yates interview with W&C; email dated January 26, 2021 at 1:51 p.m. from Dr. Shildkrot; Email dated April 1, 2021 at 11:44 a.m. from Dr. Yates to Katherine Fellows, copied to Leslie Olsakovsky and Kim Pate, re: *PFA triage*.

<sup>139</sup> Paul Yates interview with W&C; email dated February 10, 2021 at 12:50 p.m. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*; email dated April 1, 2021 at 11:19 a.m. from Dr. Yates to Katherine Fellows, copying Leslie Olsakovsky and Kim Pate.

<sup>140</sup> Paul Yates interview with W&C; email dated February 10, 2021 at 12:50 p.m. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*.

<sup>141</sup> Paul Yates interview with W&C.

call center's supervisors, and to Wendy Horton herself.<sup>142</sup> "I seriously hope a root cause analysis is performed here."<sup>143</sup> In his email, Dr. Yates not only explained how UVa's "patient friendly system" had failed, but the devastating consequences this failure had had on his own patient:

Monocular patient called in 1 month ago, stating his vision had decreased and he had only one good eye. Was told that the earliest he could see me was a month later. Vision was 20/50 on 10/27/2020, vision today is 20/200 -legally blind...This outcome has been entirely predictable...I am disappointed that our approach has led to my patient now being blind.<sup>144</sup>

On April 1, 2021, after a series of patient emergencies, Dr. Yates sent an email to the supervisor of the call center.<sup>145</sup> In his message, he compared the call system to a security failure at an airport:

To put this into perspective, we have almost the same system that the TSA uses. A single airport screening agent is tasked with identifying any concerning baggage contents. Study after study has shown that this approach inevitably fails...you will inevitably miss the weapon that sneaks through the baggage system.<sup>146</sup>

After sending off more similar emails, Dr. Yates said he felt sure this would never happen again.<sup>147</sup> A man had been blinded. The CEO, Wendy Horton, had promised him action. Surely, at this point, he thought, he would get a response.

But when that response came, he said, it was in the form of a disciplinary hearing of Dr. Yates' unprofessional conduct for the tone of emails he had written to the supervisor of the call center and his UVa management.<sup>148</sup>

### *Pediatric heart surgery*

On September 9, 2024, cardiac surgeon Mark Roeser was in surgery room 25, operating on a five-pound baby, when, he said, the room started to fill with chemical fumes.<sup>149</sup> As his team

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<sup>142</sup> Paul Yates interview with W&C; email dated March 26, 2021 at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland, copied to several others.

<sup>143</sup> Paul Yates interview with W&C; email dated March 26, 2021 at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland, copied to several others.

<sup>144</sup> Paul Yates interview with W&C; email dated March 26, 2021, at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland, copied to several others.

<sup>145</sup> Paul Yates interview with W&C; email dated April 1, 2021 at 11:44 a.m. from Dr. Yates to Katherine Fellows, copied to Leslie Olsakovsky and Kim Pate, re: *PFA triage*.

<sup>146</sup> Paul Yates interview with W&C; email dated April 1, 2021 at 11:44 a.m. from Dr. Yates to Katherine Fellows, copied to Leslie Olsakovsky and Kim Pate, re: *PFA triage*.

<sup>147</sup> Paul Yates interview with W&C.

<sup>148</sup> Paul Yates interview with W&C.

<sup>149</sup> Mark Roeser, Nina Solenski, Megan Tracci interviews with W&C.

cleared out of the room, his scrub tech passed out, then stopped breathing.<sup>150</sup> He sent her to the emergency ward, he said, then checked on the rest of his team.<sup>151</sup>

Just over one week later, on September 17, 2024, Dr. Roeser was back in surgery room 25, and the room began to fill with chemical fumes again.<sup>152</sup> In a recorded meeting following this second leak incident, Dr. Roeser and his surgical team were told just to call the fire department if the smell happened again.<sup>153</sup>

Then, on November 5, 2024, Dr. Farivar was operating in surgery room 33 when the chemical fumes returned.<sup>154</sup> He said he reported these incidents to hospital management, but he doesn't know if anyone finally addressed the problem.<sup>155</sup> Nobody in management ever explained to UVa staff what caused the leak, or what the leak was, or how to protect themselves and their patients if it happened again.<sup>156</sup>

**5. How Dr. Kent's decision to withhold resources from emergency room patients has resulted in the inhumane treatment of thousands of patients for the purpose of increasing revenues at UVa Health.**

It's been five years since Chris Ghaemmaghami, UVa Health's then-CEO and chief medical officer, wrote to President Ryan that he could no longer work with Dr. Kent, in part, because Dr. Kent showed so little interest in serving UVa's community or even taking care of UVa's patients. "He is focused on increasing revenues through surgical care and seems disinterested in exactly how we achieve this financial success," Dr. Ghaemmaghami wrote to President Ryan.<sup>157</sup>

***"It's dangerous."***

As Dr. Ghaemmaghami and Dr. Enfield, vice chair for quality and patient safety for the Department of Medicine, discussed with Williams & Connolly, not only did Dr. Kent turn away COVID patients early in the pandemic, but he has subsequently used his Emergency Department to warehouse sick patients without spending the proper resources on them.<sup>158</sup>

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<sup>150</sup> Mark Roeser interview with W&C.

<sup>151</sup> Mark Roeser interview with W&C.

<sup>152</sup> Mark Roeser interview with W&C.

<sup>153</sup> Audio recording, September 17 UVa meeting re chemical fumes in surgical rooms, in the possession of Williams & Connolly.

<sup>154</sup> Mark Roeser interview with W&C.

<sup>155</sup> Mark Roeser interview with W&C.

<sup>156</sup> Mark Roeser, Megan Tracci interviews with W&C.

<sup>157</sup> Chris Ghaemmaghami letter to UVa President James Ryan, April 7, 2020.

<sup>158</sup> Kyle Enfield, Chris Ghaemmaghami interviews with W&C.

"It's dangerous," Dr. Ghaemmaghami told Williams & Connolly. "He's willing to put dozens of patients at risk every day by prolonging their wait time in the ER, because his imperative is to generate as much revenue as possible through surgeries."<sup>159</sup>

In the past, according to Dr. Enfield, UVa could not accept a patient transferred from another hospital's emergency department unless UVa had a bed available for that patient.<sup>160</sup> Now, however, that requirement has been eliminated, and Dr. Kent has pursued a policy of increasing UVa's emergency-department-to-emergency-department transfer patients—in short, to fill its emergency ward with as many patients as possible.<sup>161</sup> As a result, UVa's Emergency Department has become so crowded with sick patients, and those patients have to wait for such long periods of time, that each week hundreds of them decide to leave without even being seen by a doctor.<sup>162</sup>

From a public health perspective, Dr. Enfield said, it's terrible policy, and he told Williams & Connolly that he warned Dr. Kent about "adverse outcomes" from "overloading the system" the very first time he met him.<sup>163</sup> But Dr. Kent has stuck with the policy.<sup>164</sup>

Meanwhile, sick patients wait side-by-side for hours in UVa's emergency ward, even as Dr. Kent has ordered his staff to keep rooms and beds empty for high-dollar elective surgery patients—particularly neurology, cardiology, and oncology patients, which, as Dr. Enfield pointed out, "pay the most."<sup>165</sup>

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<sup>159</sup> Chris Ghaemmaghami interview with W&C.

<sup>160</sup> Kyle Enfield interview with W&C.

<sup>161</sup> Kyle Enfield interview with W&C.

<sup>162</sup> Julie Speasmaker interview with W&C; UPG September 2021 letter of no confidence that begins "We are here today as fiduciaries...."

<sup>163</sup> Kyle Enfield interview with W&C.

<sup>164</sup> Chris Ghaemmaghami interview with W&C.

<sup>165</sup> Kyle Enfield interview with W&C.

**6. How Dr. Kent and Dean Kibbe retaliated against physicians who questioned their policies, even when their questions involved patient safety and protection for medical providers at UVa Health during COVID.**

Collectively, the doctors set forth below have served their community, UVa, the Commonwealth of Virginia, and their own patients for approximately 200 years. Many of them have been recognized as world leaders, both by their peers and by professional organizations, for their commitment and contribution to the advancement of medicine. But when they have raised questions with Dr. Kent's leadership team, Dr. Kent and Dean Kibbe have responded by retaliating against them. This retaliation, in some cases, has been carefully coordinated.

The accounts of this kind of conduct by Dr. Kent and Dean Kibbe are many, and they have been experienced and/or witnessed by UVa staff in multiple departments. The following are just a few of these cases:

***Case #1: Dr. John Kern, Dr. Leora Yarboro, Dr. Nick Teman, Dr. Kenan Yount***

In October 2023, it came to Dr. John Kern's attention that Dr. Preventza had not been responding to urgent messages from an electrophysiologist conducting a laser lead extraction, a high-risk procedure that requires backup from a cardiac surgeon.<sup>166</sup> The electrophysiologist had called for Dr. Preventza to be that backup, and she had failed to respond, twice.<sup>167</sup>

On October 11, 2023, Dr. Tsung, Dr. Yount, Dr. Yarboro, Dr. Nick Teman, and Dr. Preventza herself all attended their normal half-hour section meeting.<sup>168</sup>

In this meeting, Dr. Kern raised with Dr. Preventza the issue about her not answering urgent calls from the lead extraction team.<sup>169</sup> Dr. Preventza's response, he said, was dubious: she claimed she had tried to reach the electrophysicist, then yelled at Dr. Kern "this is not an issue!"<sup>170</sup> Dr. Kern said that he then stood up, told Dr. Tsung "this is wrong," and left the meeting.<sup>171</sup> Dr. Yount and Dr. Yarboro also left the meeting, and, as the meeting appeared to be over at that point, Dr. Teman, who was attending virtually, disconnected.<sup>172</sup>

On October 31, 2023, Drs. Yount, Kern, Yarboro and Teman all received a letter from Dean Kibbe, accusing them of "alienat[ing] the new Division Chief, [having] inappropriately questioned her clinical competence and skills, and [having] not shown her the respect and professionalism that is expected for all UVA team members."<sup>173</sup> Dean Kibbe characterized the way they had left their meeting with Dr. Preventza as "a blatant act of defiance, insubordination"

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<sup>166</sup> John Kern interview with W&C.

<sup>167</sup> John Kern interview with W&C.

<sup>168</sup> John Kern, Kenan Yount, Leora Yarboro, Nick Teman interviews with W&C.

<sup>169</sup> John Kern interview with W&C.

<sup>170</sup> John Kern interview with W&C.

<sup>171</sup> John Kern interview with W&C.

<sup>172</sup> John Kern, Kenan Yount, Leora Yarboro, Nick Teman interviews with W&C.

<sup>173</sup> John Kern, Kenan Yount, Leora Yarboro, Nick Teman interviews with W&C.

and “a lack of accountability to authority” and on that basis questioned their ability “to follow requests that could impact the care of patients.”<sup>174</sup>

All four of the doctors were told that this letter would remain in their human resources files, and that it could affect their future advancement prospects.<sup>175</sup> For Dr. Yount, the most junior of the four doctors, this effect has already occurred, as he was advised that he would not be considered for promotion on account of Dean Kibbe's letter.<sup>176</sup>

### ***Case #2: Dr. Mark Roeser***

Dr. Roeser, a cardiac surgeon, was assisting in a surgery at UVa when he was urgently called to attend to a patient who was dying.<sup>177</sup> According to a report later written by UVa's Quality Committee for the Heart and Vascular Service Line, Dr. Preventza had assisted in surgery on this patient the day before, and on this next day the patient started to fail, and it rapidly became clear “that the only chance to save the life of this patient was to open the chest.”<sup>178</sup> According to the same report, Dr. Preventza had instead done something that was “at best, poor decision making and at worst, patient abandonment”: she at first declined to leave a meeting she was in to attend to the patient, then, instead of going into surgery with her patient, she went off to talk to the patients' family.<sup>179</sup>

At this point, the report says, Dr. Roeser was called to help, and he “very willingly assisted in trying to save the patient’s life.”<sup>180</sup> The patient did not survive.<sup>181</sup>

Afterward, Dr. Roeser confronted Dr. Preventza about her actions, telling her that, by avoiding surgery while her patient was coding, she had lost the respect of her fellow physicians.<sup>182</sup> He also called for the hospital to conduct a review of the circumstances of the patient's outcome.<sup>183</sup>

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<sup>174</sup> John Kern, Kenan Yount, Leora Yarboro, Nick Teman interviews with W&C. Each of the doctors who walked out that day was also called to a 5-on-1 meeting with Melina Kibbe, Sue Pollart, Reid Adams, Dr. Tsung, and Wendy Horton.

<sup>175</sup> John Kern, Kenan Yount, Leora Yarboro, Nick Teman interviews with W&C.

<sup>176</sup> Kenan Yount interview with W&C.

<sup>177</sup> Mark Roeser, Leora Yarboro interviews with W&C.

<sup>178</sup> Mark Roeser, Angela Taylor interviews with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>179</sup> Mark Roeser, Leora Yarboro, Angela Taylor interviews with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>180</sup> Mark Roeser, Leora Yarboro, Angela Taylor interviews with W&C; Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>181</sup> Mark Roeser, Angela Taylor interviews with W&C. Angela Taylor letter to Credentials Committee, in the possession of Williams & Connolly.

<sup>182</sup> Jay Gangemi, Michael Ragosta interviews with W&C.

<sup>183</sup> Mark Roeser interview with W&C; Mark Roeser emails to Allan Tsung and Reid Adams.

Dr. Preventza, in turn, filed a complaint against Dr. Roeser for "unprofessional conduct."<sup>184</sup> Dr. Kim de la Cruz also filed a complaint against Dr. Roeser, in support of Dr. Preventza's complaint. Although UVa's Credentials Committee "found no evidence" to support these complaints and dismissed them, Dr. Roeser was later informed that he would not be promoted because of the complaints against him.

### ***Case #3: Dr. Paul Yates***

After struggling to draw attention to how UVa's new "patient friendly access" system kept delaying appointments for his patients with urgent needs, Dr. Paul Yates finally contacted CEO Wendy Horton.<sup>185</sup> He warned her that the new call center had caused several near-disasters with his and his colleagues' patients.<sup>186</sup>

CEO Horton assured him that she would look into the problem—but nothing happened. Then once again, a patient of Dr. Yates who was suffering with an urgent issue was improperly scheduled by UVa's "patient friendly system."<sup>187</sup> The patient went blind, and Dr. Yates sent off a spate of emails, including calling for a root-cause investigation of the matter.<sup>188</sup> This time, Dr. Yates said, after an entirely avoidable disaster had struck one of his patients, he felt sure that UVa leadership would finally respond to him.<sup>189</sup>

But when that response came, he said, it was in the form of a disciplinary hearing of Dr. Yates' unprofessional conduct for the tone of emails he had written to the supervisor of the call center and his UVa management.<sup>190</sup>

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<sup>184</sup> Mark Roeser interview with W&C. UVa Credentials Committee letter to Mark Roeser, dismissing complaints against Dr. Roeser.

<sup>185</sup> Paul Yates interview with W&C; email dated February 10, 2021 at 12:50 p.m. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*. See also email dated January 26, 2021 at 10:37 a.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Krishi Peddada, Yevgenie Shildkrot, and Alice Zhang; email dated January 26, 2021 at 2:19 p.m. from Dr. Yates to Dr. Shildkrot, copied to various others, re: *Two monocular patients mismanaged by call center*; email dated March 26, 2021 at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland; email dated March 31, 2021 at 8:58 p.m. from Maria Kirzhner to Susan Brooking, Kim Pate, and Katherine Fellows; email dated April 1, 2021 at 11:19 a.m. from Dr. Yates to Katherine Fellows, copying Leslie Olsakovsky and Kim Pate; email dated May 7, 2022 at 2:14 p.m. from Dr. Yates, copying Leslie Olsakovsky and Michael Cusick; email dated August 24, 2022 at 7:15 p.m. from Dr. Yates to Karen Warburton re: *Last comment on our approach to PFA*.

<sup>186</sup> Paul Yates interview with W&C; email dated February 10, 2021 at 12:50 p.m. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*.

<sup>187</sup> Paul Yates interview with W&C; email dated March 26, 2021 at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland, copied to several others.

<sup>188</sup> Paul Yates interview with W&C; email dated February 10, 2021 at 12:50 p.m. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*.

<sup>189</sup> Paul Yates interview with Jones Swanson; email dated August 24, 2022 at 7:15 p.m. from Dr. Yates to Karen Warburton re: *Last comment on our approach to PFA*.

<sup>190</sup> Paul Yates interview with W&C.

***Case #4: Dr. Dana Albon***

Dr. Dana Albon was elected to UVa's Faculty Senate in June, 2023, and, in a subsequent Faculty Senate meeting, she spoke up about a number of complaints she had received regarding faculty members' fear of retaliation in Dr. Kent's and Dean Kibbe's administration.<sup>191</sup> That meeting was attended by Dr. Kent and Dean Kibbe, who she said questioned her aggressively about what exactly she was afraid of, and interrupted Dr. Albon multiple times as she spoke during that meeting.<sup>192</sup> Soon after that Faculty Senate meeting, Dr. Albon was denied a promotion.<sup>193</sup>

***Case #5: Dr. Chris Kramer***

In October of 2020 Dr. Kramer tried to organize department heads to push for more pre-operative COVID testing for patients after a mass COVID exposure resulted in multiple quarantine events and the closure of the Coronary Care Unit.<sup>194</sup> Dr. Kramer was told to "stop rabblousing."<sup>195</sup> Ever since that time, Dr. Kramer has been experiencing retaliation. In one instance, Dr. Kramer was demoted when a new position, Executive Director of the Service Line, was established above him in the hierarchy of the department of cardiology to whom he now reports as head of the clinical service line.

**Answering Questions from Williams & Connolly**

From time to time during their investigation, Williams & Connolly's attorneys would pause and ask one of UVa's physicians not just for the facts, but for a possible explanation of the facts. Why, they would ask, would Dr. Kent want to strip the titles from highly esteemed and productive physicians like Dr. Chhabra or Dr. Kramer? Why would Dr. Kent and Dean Kibbe continue to support Ourania Preventza, when so many physicians had warned that she was endangering patients? In other words, why would Dr. Kent and Dean Kibbe do things that, to any reasonable observer, would seem inexplicable?

These are valid questions. However, after hearing the same stories dozens of times from dozens of physicians in various departments at UVa Health, surely the most important question now is, why would UVa continue to work with Dr. Kent and Dean Kibbe, whose decisions have been so obviously harmful, they seem inexplicable to any reasonable observer?

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<sup>191</sup> Dana Albon interview with W&C.

<sup>192</sup> Dana Albon interview with W&C.

<sup>193</sup> Dana Albon interview with W&C.

<sup>194</sup> Chris Kramer email dated October 27, 2020.

<sup>195</sup> Chris Kramer interview with W&C.

At times, Williams & Connolly's attorneys have also asked whether the decisions that Dr. Kent and Dean Kibbe have made simply reflect the state of healthcare today in America, in which hospitals are increasingly focused on making profits.

This, too, is a valid question. But would other healthcare executives order a pediatric oncologist to perform a bone marrow transplant on a child—one of the rarest and most high-risk procedures in medicine—without the necessary staffing, equipment, or supplies? Would they badger that oncologist to go ahead with a transplant even after he objected that it would be dangerous to the child?

Would other healthcare executives force the hire of an incompetent cardiac surgeon over the "resounding objection" of their own search committee, continue to support her, and dismiss numerous staff warnings about how that surgeon was endangering patients?<sup>196</sup> Would they make that surgeon chief of cardiothoracic surgery, and let her hire other surgeons?

Would other healthcare executives warn their own physicians not to sound the alarm about hospital conditions that had led to patients going blind, and surgical staff themselves having to be hospitalized?

Dr. Kent and Dean Kibbe have done all these things, which is why so many physicians have risked their careers to call for their resignation. Put simply, these physicians are asking UVa's Board of Visitors to stop the chaos, end the string of disasters that Dr. Kent and Dean Kibbe have perpetuated, and let UVa's physicians once again focus on treating patients, doing research, and training the next generation of doctors.

Sincerely,

Jones Swanson Huddell LLC

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<sup>196</sup> Angela Taylor interview with W&C.

**APPENDIX OF DOCUMENTS REFERENCED IN THE UNIVERSITY OF VIRGINIA  
DOCTORS' REPORT FOR THE BOARD OF VISITORS BOARD MEETING  
TO BE HELD ON FEBRUARY 25, 2025**

1. UPG September 2021 letter of no confidence that begins “We are here today as fiduciaries...”, referenced in footnotes 1, 2, 35, 128, 129, 131, 164.
2. Chris Ghaemmaghami letter to President James Ryan, April 7, 2020, referenced in footnotes 20, 21, 33, 113, 157.
3. UVa Faculty letter of no confidence in Craig Kent and Melina Kibbe, September 5, 2024, referenced in footnote 31.
4. Faculty Senate Resolution on One Team United Access and Culture, referenced in footnote 35.
5. Letter from Robert Powers to President James Ryan, August 14, 2024, referenced in footnote 36.
6. FACT Consulting Services Consultation Report for UVa Medical Center Children’s Hospital titled *Development of Pediatric Hematopoietic Cell Transplant and Immune Effector Cell (IEC) Program and Integration with UV Health System Adult HVT and IEC Program*, February 8, 2021, referenced in footnote 46.
7. Memorandum of Understanding attached to Dr. Trey Lee’s offer of employment, referenced in footnote 47.
8. Email exchange between Dr. Lee and his chair, Madhusmita Misra re: *Pedi SCTCT program requirements*, March 27-28, 2024, referenced in footnotes 53, 57.
9. Michael Engel email exchange with Trey Lee and Philip Roehrs, re: *transplant progress.....*, June 13, 2023, referenced in footnote 56.
10. UVa School of Medicine Announcement welcoming Ourania Preventza as new chief of cardiothoracic surgery, referenced in footnote 72.
11. *Special Review of Thoracic Surgery-Independent/Integrated Residency Program*, referenced in footnotes 76, 78.
12. Angela Taylor timeline, referenced in footnotes 68, 70, 71, 97.
13. Redacted patient record, page 2 of 3, referenced in footnotes 102, 103.
14. Chris Kramer email dated October 27, 2020, referenced in footnotes 120, 195.

15. June 2020 letter to Kent that begins "As the Public Directors, we represent...", referenced in footnotes 126, 127, 129.
16. Letter written in June of 2021 that begins "We would like to better understand...", referenced in footnotes 126, 127, 129.
17. October 2021 draft letter that begins "We are here today as concerned fiduciaries...", referenced in footnotes 126, 127, 129.
18. Letter to Public Directors that begins "I want to tell you...", referenced in footnotes 126, 127, 129.
19. Letter to President Ryan that begins "Thank you for taking the time to meet with us today," referenced in footnotes 126, 127, 129.
20. Emails regarding credit holds and outstanding invoices from Cordis, Phillips, and Boston Scientific (including spreadsheet listing outstanding invoices), referenced in footnote 128.
21. Email dated January 26, 2021 at 2:19 p.m. from Dr. Yates to Dr. Shildkrot, copying many others, re: *Two monocular patients mismanaged by call center*, referenced in footnotes 136, 185.
22. Email dated January 26, 2021 at 10:37 a.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Krishi Peddada, Yevgeniy Shildkrot, and Alice Shang, referenced in footnote 137 and 185.
23. Email dated January 26, 2021 at 1:51 p.m. from Dr. Shildkrot, referenced in footnotes 137, 138.
24. Email dated April 1, 2021 at 11:44 a.m. from Dr. Yates to Katherine Fellows, copied to Leslie Olsakovsky and Kim Pate, re: *PFA triage*, referenced in footnotes 138, 145, 146.
25. Email dated February 10, 2021 at 12:50 P.M. from Dr. Yates to Wendy Horton, copied to various others, re: *Substantial ongoing issues with PFA in Ophthalmology*, referenced in footnotes 139, 140, 185, 186, 188.
26. Email dated April 1, 2021 at 11:19 a.m. from Dr. Yates to Katherine Fellows, copying Leslie Olsakovsky and Kim Pate, referenced in footnotes 139, 185.
27. Email dated March 26, 2021 at 3:30 p.m. from Dr. Yates to Kim Pate, Katherine Fellows, Leslie Olsakovsky, Kimberlee Daniels, and Peter Netland, copied to several others, referenced in footnotes 142, 143, 144, 187.
28. Mark Roeser emails to Allan Tsung and Reid Adams, referenced in footnote 183.

29. UVa Credentials Committee letter to Mark Roeser, dismissing complaints against Dr. Roeser, referenced in footnote 184.
30. Email dated March 31, 2021 at 8:58 P.M. from Maria Kirzhner to Susan Brooking, Kim Pate, and Katherine Fellows, referenced in footnote 185.
31. Email dated May 7, 2022 at 2:14 P.M. from Dr. Yates, copying Leslie Olsakovsky and Michael Cusick, referenced in footnote 185.
32. Email dated August 24, 2022 at 7:15 P.M. from Dr. Yates to Karen Warburton re: *Last comment on our approach to PFA*, referenced in footnote 185, 189.

# **APPENDIX, DOCUMENT #1**

We are here today as fiduciaries of UVA Health. We sit on UVA Health boards, we are UVA Health patients, we are dedicated members of the Charlottesville community, and we all want to see UVA Health thrive. All of us have given our time to help UVA Health meet the needs of the UVA clinicians and nurses as well as the patients in the community.

Most of us participated in the search committee process to identify the priorities for the EVP position. The priorities were: Building trust (and the importance of transparency to achieve that), creating alignment through collaboration across the health system, and developing a strategic plan. For such a plan to be successful, it was emphasized that physician leaders would need to be included in the planning process.

Each of us has examples of how these priorities are not being met. We believe that many of these have already been shared with you. I have also had numerous conversations with UVA physicians and nurses. They have described the very negative, and sometimes, bullying experiences they have had with leadership. At the same time, Craig has spent millions (at least \$12 million) on consultants and new administrative hires while simultaneously pushing aside almost all prior physician leaders, completely dismissing the valuable insights and contributions of leaders who have spent decades devoting themselves to UVA Health. None of his new administrative leadership hires are physicians. Wendy Horton, the CEO of the Medical Center, was hired without any search, something that as far as we know has never been done before.

We understand that the pandemic impacted operations, yet one of Craig's very first actions was to furlough employees and cut salaries, at the same time that he was making several expensive hires of administrative chiefs and consultants. Instead of looking out for them, like Novant that gave their health system employee's bonuses or VCU that had no furloughs or pay cuts, Craig's actions undermined their trust and left them feeling devalued and unappreciated. As a result, many of them have left or are in the process of leaving. There are currently 300 unfilled nursing positions and over travel nurses. The cost of the travel nurses is more than double the cost of our staff nurses, including salary, signing bonuses, housing allowances and incentives. Many of the most experienced physicians have left or stepped down as chairs, only to be replaced by younger, less experienced ones. A number of administrative leaders at UPG have recently resigned due to the frustration and difficulty working with UVA Health leadership.

We are concerned about the worsening reputation of UVA Health in the community. UVA is no longer the #1 hospital in the state and no departments were ranked in the top 50 in the country. The patient satisfaction scores have declined significantly. As one physician said to me, "We're not here to be average, and UVA is losing its academic prestige."

There is still no strategic plan for UVA Health. Craig has been here almost 20 months, and is still waiting for input from the new chief strategic planning officer, from groups within the health system and the community. If the purchase of the 3 northern Virginia hospitals is any indication of what's to come, UVA Health is in big trouble. What he described as the plan for those hospitals was very vague and really wasn't a plan, more like wishful thinking, such as "we'll run the hospitals better." Furthermore, 3

weeks after the purchase, the doctors at these hospitals knew nothing-“We’re walking in the dark.” Several resigned in those first weeks, and more were planning on it. A strategy should have been in place months earlier, especially the engagement of the Novant physicians with the UVA physicians.

We have repeatedly attempted to work with Craig. The previous chair of UPG, George Pace, spent hours working on a strategic plan for UPG with him. One agreed upon goal was the implementation of Funds Flow. In January 2021, when I started as chair, that goal was nowhere to be found. George has essentially wasted hours talking with Craig, as I have since January. He does not listen and he does not care. Instead, he tries to pacify us with platitudes and rhetoric.

We have lost confidence in his ability to lead UVA Health, and we are here today to express a verbal vote of no confidence in Craig Kent. Understanding that we have no authority over him, we are coming to you to seek help.

Here are our questions:

1. Were these themes present in Craig’s recent 360 evaluation?
2. Are you willing to re-engage Merritt-Hawkins to immediately assess the leadership and climate?
3. What plans, if any, do you have to address this situation?

## **APPENDIX, DOCUMENT #2**

President, University of Virginia  
Charlottesville, VA

April 7, 2020

Dear Jim,

Thank you again for meeting with me on Friday, April 3<sup>rd</sup> to discuss my decision to resign from the position of interim CEO of the UVA Medical Center. Having the opportunities to serve in this role and as the co-chair of the health system transition committee have been the highest honors of my career at UVA. The past 12 months have been tumultuous, and I have been gratified to help lead the health system through the period after the resignation of our past EVP, the challenges of the billing and collections improvement effort, and now the COVID-19 epidemic.

I write to you today to clarify my rationale in resigning, and I trust that you will hold these remarks in strict confidence. Shortly after Dr. Kent started at UVA, I became aware of incompatibilities between our leadership styles, and possibly, our core values as physicians and healthcare administrators. I feel I need to share these observations with you in order for you to ensure the best outcome with Craig at the helm.

I suspect that Craig and I have deep philosophical differences on the desired direction and mission of the health system. I have spent years working to improve safety, quality, and value of care for our patients in the Charlottesville community and throughout the Commonwealth. He is focused on increasing revenues through surgical care and seems disinterested in exactly how we achieve this financial success. It is unclear to me whether or not he believes in being both great and good in alignment with the framework you have created at UVA.

In terms of leadership, Craig appears to be leading from a place of fear rather than courage. In my opinion, he is consumed by the need to ensure that we avoid any errors, not because of the direct outcome, but because he will be held accountable by you and the board. This has led him to be slow and deliberate in decision-making to the point where the prerequisite for a decision is not just data, but also waiting to see the decisions of as many national peer organizations as possible before acting. He told me directly that he "doesn't want to be first or last" in any decision, but would rather be in the middle. I believe he must have been scarred by prior negative experiences leading him to this place of cautiousness. For me, this means we will be destined to be laggards –not leaders – in academic medicine.

Another leadership and management challenge revolves around Craig's tendency to micromanage the teams and communications. It was in the first week after his arrival, when he made it clear that no communications about the billings and collections reform effort would be released without his review and approval. This seemed fair enough, but the result was that we essentially stopped communicating at all – even with internal constituents groups like faculty and staff. During this same period, he insisted

I complied.

Moving forward a few weeks, the control over communications was extended to become a ban on broad communications from any of the senior leaders (Deans of SON or SOM, MC CEO, or UPG president) to our own employees. This has reduced open communication in our organization and created a level of opacity which is in direct contradiction to my operating principles on transparency.

As you know, Craig has now removed two of my direct reports from the MC senior management team – having made these decisions prior to discussing them with me and with the expectation that I be totally aligned. Additionally, the replacement for the Chief Medical Officer position was contacted and offered the job prior to me even knowing that the job was in play. I have also learned that Craig has repeatedly met with my direct reports to discuss substantive issues and made decisions about actions or duty assignments without my knowledge. The decision making is top-down, and it has been made clear to me that alignment and loyalty are expected in this new administration.

There is no better example of this command and control structure than Craig's refusal to operate under any of the widely accepted emergency management systems during this coronavirus pandemic. Instead, he conducts a daily meeting where he sets the agenda, dominates the discussion, and informs us of his decisions. His system may work, but it conflicts with all of my training on leadership and management, as well as my personal leadership style. It also belies the lack of trust he has in his team's competence and his willingness to be responsible for taking a risk based on our recommendations. All of these actions have obviated the need for a separate medical center CEO under these conditions.

The longer we worked together, the more clear it became that the only way to make this relationship work would be for me to suppress my better judgment and authenticity and fall in line. My integrity is paramount to me, and I know that this proposition would not be effective, sustainable, or honest in the long term. I aspire to be professional and respectful, so I felt it was right to clear the way for Dr. Kent so that he can build a team of like-minded leaders, thus avoiding a public conflict or another larger destabilizing event.

I know that it must be disappointing for you to read this assessment. As I hope I have explained, I am not telling you this to undermine Craig, but to explain my decision and to help you redirect Craig's effort if you agree that any of these observations are problematic. His command and control system may actually work with the team of his choosing, but I cannot see myself in a leadership role on that team.

Finally, I am sensitive to the concept that some observers outside of the leadership team may believe I should be faulted for leaving during a crisis, and I would like to dispel that misconception. First, UVA is well-prepared. The work of the University and medical center teams under J.J. Davis's and my leadership, respectively, have put UVA in a solid position to work our way through the next phases of this disaster. I am enormously proud of the way the health system team has pivoted our entire operation to a posture of readiness and disease mitigation in just 4 weeks. In light of the new EVP's leadership style, my decision-making has now become superfluous and will barely be missed. Second, I am not leaving; rather, I am redeploying my efforts and skills where they are now most valuable. I will

period of the COVID-19 epidemic.

Since 2014, I have systematically dismantled my academic career and diminished my national reputation in a total effort to support UVA Health. I have been less concerned about the trajectory of my career than I have been about the success of the organization. Hopefully, my actions this week continue to reflect this ethic and my loyalty to the institution. You told me on Friday that I have "exactly the right values" for this organization. I would like to believe this is true. So, I am stepping aside with my values and integrity intact in a respectful manner. I do this with the hope that Dr. Kent will be successful and thereby achieve the greater good for the health system and UVA as a whole.

Yours Faithfully,



Chris A. Ghaemmaghami, MD  
Professor of Emergency Medicine  
UVA School of Medicine  
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# **APPENDIX, DOCUMENT #3**

# URGENT MATTER OF PATIENT SAFETY AND PUBLIC CONCERN

## LETTER OF NO CONFIDENCE IN CRAIG KENT, CEO OF UVA HEALTH

### MELINA KIBBE, UVA SCHOOL OF MEDICINE DEAN

*"...any leader—at any level—depends on the trust and support of the people he or she represents. If that trust is lost, for whatever reason, it is exceedingly difficult to continue to lead."*

*— University of Virginia President James Ryan*

To the Rector and Board of Visitors of the University of Virginia:

We sign this letter of no confidence as ethical, principled, and dedicated professors and health care professionals committed to our patients, colleagues, community, and the University of Virginia.

It is our duty to protect the safety of our patients and community, as well as the quality, welfare, honor, and reputation of the University of Virginia and our medical profession.

Craig Kent and Melina Kibbe have not only undermined but also directly attacked the values that inspired us to study, teach, and work at the University of Virginia School of Medicine and UVA Health.

Craig Kent and Melina Kibbe foster a negative environment that is contributing to an ongoing exodus of experience and expertise at all levels that contravenes our mission to provide excellent—and safe—patient care.

This environment has led to egregious acts, which must no longer be tolerated:

#### **COMPROMISED PATIENT SAFETY**

- Pressuring physicians, nurses, and other staff to abstain from using the Be Safe process to report patient safety concerns.
- Hiring doctors despite concerns regarding integrity and quality known in the medical community and communicated to leadership.
- These actions threaten the safety of our patients and reputation of our health care programs.

#### **CULTURE OF FEAR AND RETALIATION**

- Using explicit and implicit threats and retaliation—often relayed to faculty via their chairs and chiefs—against those who have raised concerns about patient safety, capacity constraints, and moral distress.

## **URGENT MATTER OF PATIENT SAFETY AND PUBLIC CONCERN**

- Responding to concerns and questions raised by faculty in open forums with ridicule and disrespect.
- Subverting the true intent of credentialing, quality review, and professional support processes to silence and intimidate faculty.

## **DEVALUING THE ACADEMIC STANDARDS OF PROMOTIONS AND TENURE**

- Using delays and denials of promotion and tenure as retaliation against respected faculty for speaking out about patient safety concerns, a culture of fear and retaliation, and unethical behavior by UVA Health senior leaders.
- Implementing non-transparent and inconsistent standards regarding academic rank and compensation for new hires relative to existing faculty.

## **EXCESSIVE SPENDING ON C-SUITE EXECUTIVES AND SUPPORT**

- Continued significant expansion of the number of C-suite executives, Chiefs of Staff, Special Advisers, other supporting personnel, and resulting expenses not allocated to patient care that could otherwise address ongoing clinical and technical staff shortages.
- In parallel with this expansion, sustained expenditure and reliance on consultants.

## **FAILURE TO BE FORTHCOMING ON SIGNIFICANT FINANCIAL MATTERS**

- Concerns include audit performance, the communication regarding the recent transition of the Chief Financial Officer, Community Health acquisitions, Revenue Cycle, and UPG funds flow.

## **CONSISTENTLY VIOLATING THE BOARD OF VISITORS APPROVED CODE OF ETHICS IN THE UNIVERSITY OF VIRGINIA FACULTY HANDBOOK**

- Failure to protect confidential reporting and internal whistleblowing.
- Disregarding valid reports of fraudulent billing and requests by senior leaders to fraudulently modify patient records in order to obfuscate adverse outcomes and boost productivity metrics.
- Systemic disregard of policy, procedure, regulation, and fiduciary responsibilities including but not limited to the following UVA Faculty Handbook Professional Conduct and Ethics Codes:

**1. Compliance and Ethics:** *We perform our responsibilities ethically and honestly, in compliance with all University policies and applicable to federal, state, and local laws.*

**2. Use of University Resources:** *We use University resources only for their intended business purpose, as aligned with the University's mission. We promote accurate financial reporting, protection of the University's assets, and responsible fiscal management. Our expenditures are reasonable and necessary.*

## URGENT MATTER OF PATIENT SAFETY AND PUBLIC CONCERN

*7. **Respectful Workplace:** We treat every individual with kindness, dignity and respect, regardless of position or status. We provide a safe and healthy environment for working, living, and learning. We collaborate with others in a positive and respectful manner.*

*8. **Honesty and Integrity:** We act and communicate honestly and with integrity, upholding the University's values at all times. We do not condone dishonesty by anyone in any form, including fraud, theft, cheating, plagiarism or lying.*

*9. **Reporting Without Fear of Retaliation:** We report all violations of law or University policy, without fear of retaliation for reports made in good faith. We investigate all concerns and determine corrective action. We will cooperate with all investigations into suspected wrongdoing.*

### WEAPONIZING ASPIRE VALUES

- Senior leaders of UVA Health have and continue to use ASPIRE Values to punish and intimidate faculty—often in the form of letters placed in Human Resources and Departmental files that have been referenced as cause to withhold recommendations for promotion and tenure.

### SUBJECTING RESIDENTS TO BULLYING AND HARASSMENT

- Repeated instances of abusing the power dynamic between UVA Health senior leaders and trainees which culminated in disturbing and heartbreaking Graduate Medical Education reports that were suppressed, minimized, and subsequently altered.

For over a year, these concerns and egregious acts were reported via UVA's official reporting processes including emails, a resolution by the School of Medicine Faculty Senate Representatives, and multiple meetings with UVA leadership.

Many faculty, doctors, nurses, and staff who have shared these legitimate concerns have been silenced, intimidated, and/or punished for following recommended UVA reporting protocols.

Some leaders have dismissed many of these concerns as those of a disgruntled few. This letter and these signatures demonstrate that these leaders are disconnected from the organization that they have been entrusted to lead.

We sign this letter of no confidence as a last resort out of urgent concern for our patients, colleagues, community, and the University of Virginia.

### **We call for the immediate removal of Craig Kent and Melina Kibbe.**

We urge the Board of Visitors to select new leaders for UVA Health and the UVA School of Medicine who are committed to upholding UVA's cherished values; defending academic freedom and free speech; and most importantly recommitting to exceptional patient care, safety, and the well-being of our doctors, nurses, and staff.

**URGENT MATTER OF PATIENT SAFETY AND PUBLIC CONCERN**

**Sincerely,**

*(Signatures signed, verified, and maintained under seal.)*

# **APPENDIX, DOCUMENT #4**

**SCHOOL OF MEDICINE FACULTY SENATE RESOLUTION ON  
One Team | United Access and School of Medicine Culture**

**WHEREAS**, UVA Health launched One Team | United on Access (OTUA) in July 2022 in order to provide best-in-class experience for patients, their providers and clinic teams;

**WHEREAS**, several open and independent letters have recently been sent to leadership from multiple groups of School of Medicine (SOM) faculty members which bring to light significant concerns regarding the implementation of OTUA – letters that come on the heels of previous rollouts of OTUA (including surgical subspecialties) during which similar concerns were expressed but remain unaddressed;

**WHEREAS**, UVA Health senior leaders’ responses to these letters have implied that the SOM faculty have had a valuable seat at the table in shaping OTUA, however SOM faculty, even those who have participated, believe such statements to be misleading;

**WHEREAS**, OTUA has not allowed for local control to individual clinics to account for operations, staffing challenges, electronic medical record usage, and the complexity of the caseload and problems being evaluated. There is evident and significant provider dissatisfaction with the current top-down implementation, which inevitably leads to increased burnout in the provider community. This burnout and dissatisfaction potentially risks losing providers to other jobs or early retirement across subspecialties, and especially in the primary care setting. Due to the paucity of primary care providers nationwide, the current process risks decreasing patient access through the loss of providers and inability to hire new faculty. In addition, OTUA could negatively impact faculty recruitment overall as faculty in academic medicine do not want this level of micromanagement and lack of autonomy;

**WHEREAS**, scheduling constraints inherent to OTUA are in contradiction to the academic requirements for promotion and tenure: In order to achieve promotion, a faculty member needs to achieve excellence in teaching, research, and/or clinical care depending on the track, AND there needs to be recognition at the regional, national, and international level, provide service to the university and clear evidence of scholarship. The four-hour block significantly limits providers’ ability to accommodate meetings that interfere with clinic schedules. Therefore, faculty may not be able to serve the university and/or regional national organizations through committees, participate in research projects with multiple researchers (on grounds or nationally), or build a national and international reputation needed for promotion and tenure;

**WHEREAS**, OTUA does not take into consideration the presence of students, residents, and/or fellows in clinics that are not specifically teaching clinics, and does not integrate them in the current attending clinic flow thereby negating any time for teaching in between patients. OTUA does not consider student teaching blocks in the medical school – faculty have been informed that they could not block certain clinic times to provide these services for the SOM;

**WHEREAS**, we do not know of any data that show the current four-hour block has been shown to improve patient satisfaction or patient outcomes, increase relative value units (RVUs), or decrease patient cost. It does not allow for variations required in the templates for multidisciplinary clinics with multiple specialties providing care under the same encounter or for specialties caring for complex patients who require prolonged visits, thereby essentially decreasing access for patients with complex medical histories.

**WHEREAS**, there remains inadequate infrastructure support (*e.g.*, staffing, ancillary services, *etc.*) to accommodate for the level of effort expected of faculty providers;

**WHEREAS**, it is the understanding of the SOM Faculty Senate that UVA Health senior leaders have followed up with some Department Chairs and other leaders so that they may caution faculty who have already expressed their views to *stand down* and discourage faculty from raising concerns at open forums on a variety of topics of late, especially OTUA. This, along with confidential reports from current and former faculty regarding specific responses and behavior from SOM leadership has created a Culture of Fear and Retribution amongst many faculty members. The SOM is governed by a Code of Conduct requiring all faculty, including UVA Health senior leaders, to commit to avoiding all forms of harassment, threats, intimidation, and bullying. Central to that commitment is the principle of treating each UVA SOM community member with respect;

**WHEREAS**, the most recent AAMC StandPoint Survey highlighted a disconnect between SOM faculty and UVA Health senior leadership, with the lowest degree of satisfaction regarding clinical operations;

**WHEREAS**, the SOM Faculty Senate hopes to maintain confidence in SOM leadership by helping restore a Culture of Trust;

**AND WHEREAS**, the SOM Faculty remains aligned with the University's strategic commitment to being both Great and Good, *which codifies our core values and establishes a unifying vision to be the nation's public leading academic health system and best place to work.*

**NOW THEREFORE, BE IT RESOLVED** that the UVA SOM Faculty Senate, representing the entire SOM Faculty, requests the following from the UVA SOM Dean and Leadership:

1. To implement a **PAUSE** in OTUA rollout so that current problems can be addressed and resolved. These problems include:
  - a. No flexibility within four-hour sessions especially with child care and personal issues.
  - b. Decrease in access for patients with multiple and/or complex problems.
  - c. Lack of control at the department level regarding clinic sessions.
  - d. Threat of diminished teaching to medical students, residents, and fellows.

- e. Threat of diminished participation of junior faculty members in workshops (e.g., grant writing) that are needed to promote their academic career and secure funding.
  - f. Threat of diminished participation in Committee work.
  - g. Inability to meet promotion and tenure requirements due to the current clinical constraints on faculty members.
  - h. Lack of data for the faculty to understand the current rationale for the four hour clinic implementation and the outcomes for our community.
2. To schedule a stand-alone General Faculty Meeting within four to six weeks of receipt of this resolution to enable SOM voting faculty members to openly and safely voice concerns about OTUA to SOM leadership.
  3. To facilitate participation of clinical faculty members (representing ALL SOM departments) on OTUA panels and decision boards in order to provide a voice for faculty and build from the bottom up. This includes initiating flexibility in current clinic schedules to address the problems described above (#1) and to enable more control at the department level.
  4. To provide data to SOM Faculty every 6 months addressing RVUs, cost, patient and staff satisfaction, and implications of these changes in faculty retention and recruitment.
  5. To acknowledge and eliminate the Culture of Fear and Retribution currently present in the SOM amongst faculty with regard to bringing up dissenting views or objections.

**BE IT FURTHER RESOLVED**, that the SOM Faculty Senate conveys a clear expectation that any faculty member who agrees with this resolution or brings forward related concerns not be the subject of retaliation, threats, intimidation, or bullying by any University of Virginia or UVA Health employee.

**Respectfully submitted,**

**The University of Virginia School of Medicine Faculty Senate**

*Delivered to and discussed with Executive Vice President & Provost Ian Baucom and Vice Provost for Faculty Affairs Maité Brandt-Pearce on Tuesday, January 9, 2024.*

*Added to agenda for President James Ryan on Wednesday, January 10, 2024.*

# **APPENDIX, DOCUMENT #5**

President James Ryan  
Provost Ian Baucom  
University of Virginia

14 August 2024

I write in response to your solicitation of faculty comments regarding Health System Leadership and the current environment at the UVa Medical Center. By way of introduction, I am a graduate of the UVa Medical School in my second stint on the faculty, with a rank of Professor and total service here approaching 30 years. This has included beginning as a full time clinician, and eventually moving into various junior and senior leadership roles in academic departments, at the Medical Center, and Health System. I have served under and along with many Deans, Department Heads, Hospital and Health system leaders.

Our current senior leadership at the Health System level is the worst I have been associated with. If I thought this was a matter for humor, I would describe their style as "never in doubt and occasionally correct". It is unfortunately not a laughing matter. The current culture stands in opposition to foundational principles associated with academic medicine, including compassionate patient care, teaching, collaboration, transparency, respect and dignity.

This is a closed, secretive, top-down group who manage by fiat, threat, intimidation, random and punitive demotions and firings, and suppression or delay of release of information or circumstances they deem unfavorable. Data and statistics are massaged and gamed to make things appear positive, but it seems that there has been an inexorable decline in quality, patient, and faculty/staff satisfaction.

We have also seen an unwelcome and very expensive move toward management-by-outside-consultant. Local managers and administrators are confused and disheartened by this, as it implies that they do not have sufficient knowledge to run their own departments, manage change, and develop strategy. Consultants often present with a pre-devised plan, rather than gathering data, interviewing and actually listening, and coming up with a relevant recommendation that suits the needs and local environment. This is dismissive and wasteful in what is supposed to be a collegial, transparent, and cost conscious environment.

I lay this situation and culture directly at the feet of Dr Kent. He is known for retribution against those who speak out against his plans or approach, and has peopled his senior staff with cronies and former subordinates who are loyal to him and his way of doing things. It is widely believed that some of these positions have been filled without proper and transparent searches. Specifically, this pertains to the appointment of the current hospital CEO, a former subordinate colleague of Dr Kent's. The SOM Dean apparently served under Dr Kent as a Fellow during her training...unlikely coincidences, i think.

Additionally, I and my colleagues were amazed and dismayed to hear recently of Dr Kent's seven-year contract renewal. This is essentially a lifetime appointment for someone of his age, and offers no hope of a change in leadership or style for the foreseeable future. I recall no solicitation of opinion or input from senior faculty regarding this renewal process; it seems to have been done quietly and quite privately. Our health system was not in crisis when he was appointed, and in no need of rescue by someone with this well-documented management style and attitude.

The effects of this toxic culture and leadership failures are evident across the spectrum of the health system. Operational efficiency, clinical care, safety, quality, morale, recruiting, and reputation are all distressed and appear headed toward further decline.

Most of us are aware that Dr Kent was the subject of a "no-confidence" letter written by senior faculty at Ohio State not long before he was named to his current post at UVa. That letter details behavior by Dr Kent and his senior associates that closely mirrors what we are currently experiencing. This is not a coincidence.

My prediction is that Dr Kent and many of his senior leadership group would not survive a no-confidence vote from the Faculty if one was taken today. Perhaps we should find out...this is a unfortunate and regrettable situation that needs resolution promptly.



Robert D. Powers MD MPH  
Professor, Dept of Medicine  
UVa Health System

# **APPENDIX, DOCUMENT #6**

# UNIVERSITY OF VIRGINIA MEDICAL CENTER CHILDREN'S HOSPITAL

## FACT CONSULTING SERVICES

Professionals in the field of cellular therapy:  
FACT Consultants help shape, implement, and embed best practices.

JEAN E. SANDERS, MD  
FEBRUARY 8, 2010

*Expert Advice.*



Consultation Report for:

University of Virginia Medical Center Children's Hospital

Development of Pediatric Hematopoietic Cell Transplant (HCT) and

Immune Effector Cell (IEC) Program and Integration with UV Health System Adult HCT and IEC Program

Virtual Consultation: January 22, 2021

Submitted by: Jean E. Sanders, MD

February 8, 2021

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## Abbreviations

AABB	formerly American Association for Blood Banking, now known by initials only
APP	Advanced Practice Provider/Professional
ASA	American Society Anesthesiologists
ASFA	American Society for Apheresis
ASTCT	American Society of Transplant and Cellular Therapy
BSC	Biological Safety Cabinet
CAP	College of American Pathologists
CFR	Code of Federal Regulations
CFU	Colony Forming Unit
CIBMTR	Center for International Blood and Marrow Transplant Research
CMV	Cytomegalovirus
CRS	Cytokine Release Syndrome
FACT	Foundation for the Accreditation of Cellular Therapy
FDA	U.S. Food and Drug Administration
FWA	Federal Wide Assurance
cGMP	Current Good Manufacturing Practices
cGTP	Current Good Tissue Practices
HEPA	High Efficiency Particulate Arrestance
HCT	Hematopoietic Cell Transplantation
IDE	Investigational Device Exemption
IND	Investigational New Drug
ISCT	International Society for Cellular Therapy
LN2	Liquid Nitrogen
PBSC	Peripheral Blood Stem Cells
QM	Quality Management
QMP	Quality Management Plan
SOP	Standard Operating Procedure
TJC	The Joint Commission

## **Overarching Hematopoietic Cell Transplant/IEC Program Strategy**

The overall goal of the University of Virginia Medical Center Children's Hospital is to develop a pediatric hematopoietic cell transplant (HCT) and an Immune Effector Cell (IEC) program and to integrate with the FACT Accredited UV Health System Adult HCT and IEC program to ultimately achieve FACT Accreditation as a combined adult and pediatric FACT Accredited HCT and IEC Program.

### **Introduction**

A combined pediatric and adult program must demonstrate common staff training, protocols (where appropriate), SOPs, Quality Management systems, clinical outcome analyses and regular interactions among all clinical sites (FACT Standard 1.1.1). Evidence that there is sufficient integration could include: (1) common or equivalent staff training programs, especially for nurses such as in-service training and competency testing on the same topics,

(2) common or equivalent controlled documents such as forms, flow sheets, policies and SOPs. For example, management of fever, prophylactic antibiotics, antiviral and antifungal prophylaxis, GVHD prophylactic and or treatment regimens and administration guidelines for medications or blood components.

(3) regular interaction such as attendance at meetings and conferences that are regularly scheduled, such as regularly scheduled conferences for morbidity and mortality, quality assessment and improvement, patient assessment and patient outcomes.

The Pediatric Team notes that a number of children in Virginia go out-of-state for autologous or allogeneic HCT or IEC therapy. Once the program is developed at University of Virginia Children's Hospital, the team believes that it will be able to achieve the number of required allogeneic transplant per year to achieve and maintain FACT Accreditation as a combined program. By year 3, the program estimates there may be at least 4 autologous, 5 allogeneic transplants and 4 IEC therapy patients with annual numbers from that time anticipated to increase.

In making recommendations for personnel, space and equipment, the number of 10 HCT/year (autologous and allogeneic) and 4-5 IEC therapy was used to estimate needs. The cellular therapy product would be peripheral blood stem cells (PBSC) for autologous or peripheral blood mononuclear cells collected for IEC product manufacture by a third party (e.g. Kite or Novartis). The cellular therapy product for allogeneic related donor HCT would be either bone marrow or PBSC.

A HCT program consists of three (3) major areas working together to conduct the HCT for patients in a safe and high-quality manner that will be in the patient's best interest and provide the best possible clinical outcome. These areas include the Clinical Program, the Collection Facility (Apheresis Collection and Bone Marrow Harvest Collection) and the Processing Facility. The developing Pediatric HCT and IEC program will use the already FACT Accredited Adult Apheresis Collection Facility and the Processing Facility. Recommendations in this report cover all of these areas and are based on FACT 7<sup>th</sup> Edition Standards and the experience of the FACT Consultant.

## Capacity and Physical Space Requirements

### Pediatric Clinical Program

**In-Patient Unit:** Pediatrics is located on the 7<sup>th</sup> floor in the main university hospital. The team has identified four (4) single patient rooms, that are HEPA filtered and each have private bath for the HCT/IEC patients. These rooms are off the main traffic flow. Each patient room is large enough to accommodate a family member to be able to spend the night with the patient. Each patient room has a TV, and all other monitoring capabilities.

The average allogeneic patient will remain as an in-patient approximately 5-6 weeks post-HCT and depending on the conditioning regimen an additional week pre-transplant for administration of the conditioning regimen. Thus, the average initial in-patient stay is approximately 7 weeks. Autologous pediatric patients, such as those with neuroblastoma, will usually have the conditioning regimen administered as an in-patient as well. Their in-patient stay post-HCT may be slightly shorter than the allogeneic recipient depending on post-HCT complications. Published data show that 40% of allogeneic patients and 24% of autologous patients require 1-3 hospital readmissions for treatment of complications.<sup>1</sup> Transplant patients who require readmission after initial discharge should be readmitted back to the in-patient transplant unit or designated HCT room. Taken all together (allogeneic and autologous), it is reasonable to figure about 8 patients/bed/year.

Immune Effector Cell: These patients receive a conditioning regimen for lymphodepletion with Cyclophosphamide and Fludarabine given over 3-4 days prior to infusion of the IEC product. While experienced programs may give this regimen as an out-patient, it is recommended that initially the therapy be administered as an in-patient, especially for the pediatric patient. Infusion of the IEC product should also be done as an in-patient. A high percentage of IEC patients will require hospital admission within 4-7 days after infusion of the IEC cells for treatment of complications including Cytokine Release Syndrome and/or neurologic complications. Some of these patients may require ICU admission.

The in-patient unit should also have a satellite pharmacy (either on the unit or very near-by), nurses' station, family room, 1-2 conference rooms, unit assistant space and office space for physician(s), fellows and APP(s). The pediatric floor has a treatment room for performing procedures, but the team will need to consider if a triage room equipped with examination table, examination equipment is needed for seeing patient's afterhours or on weekends. Space for an infusion cart with supplies and reagents used for bedside thawing of cryopreserved products and infusion of other cellular therapy products will be needed.

*There shall be provisions for prompt evaluation and treatment by a transplant attending physician available on a 24-hour basis (FACT Standard 2.6). This may be accomplished by utilizing in-house general pediatric physicians or APPs as long as the scope of responsibility is defined and there is HCT attending physician oversight (FACT Standard 2.10).*

There needs to be ready access to a pediatric intensive care unit (ICU) for prompt transfer of patients when appropriate (FACT Standard 2.7). The pediatric floor has a PICU nearby so this will not be a problem.

**Out-Patient Facility:** There shall be a designated out-patient care area that protects the patient from transmission of infectious agents and allows, as necessary, for appropriate patient isolation, confidential examination and evaluations and administration of intravenous fluids, medications and/or blood products (FACT Standard 2.2). The 5<sup>th</sup> floor of the Battle Building is a mixed-use floor where the pediatric hematology/oncology patients are seen along with other pediatric patients. The floor has a large waiting room/reception lobby, but consideration needs to be given to how the HCT/IEC patients will be protected from potential exposure to infectious agents. Developing a separate waiting room/reception space for these patients may be needed. The out-patient facility should include clinic rooms, conference rooms, infusion bays, pharmacy, nursing station, offices, blood draw space and patient waiting room. Each of these areas are discussed below.

**Clinic Rooms:** Clinic rooms should be dedicated for HCT and IEC patients. Clinic examination rooms should be equipped with standard examination table, instruments for HEENT examination, computer, chair or bench for family member accompanying the patient, cabinet for supplies.

These clinic rooms would be utilized for the Allogeneic patient evaluation pre-transplant and post-HCT care after hospital discharge, for allogeneic family member donor evaluations pre- and post-donation of either bone marrow or PBSC. Majority of allogeneic patients will be followed by the HCT team for minimum of 100 days post-HCT. For Autologous patient evaluation pre-transplant, care during PBSC mobilization, care post-PBSC collection before hospitalization for transplant and care post-hospital discharge before discharge to primary care referring physician. Similarly, these clinic rooms would be utilized for the IEC patient for initial evaluation, post-leukapheresis care and potential administration of bridging chemotherapy (if needed) while awaiting manufacture of the IEC product (about 4-6 weeks), and follow-up during the initial 30 days post-IEC product administration and beyond if needed.

Using an estimated volume of about 15 patients/year (HCT and IEC), at least 2 examination rooms should be identified. Pre-transplant and Pre-IEC evaluations take place in the out-patient area and require several clinic visits for each patient to complete evaluation. Post-transplant allogeneic patient average number of clinic visits is 22 (arrange 13-32), for autologous patients the average number of clinic visits is 21 (range 12-30)<sup>1</sup> and for post-IEC administration, patients are seen frequently for the first 30 days.

**Conference Rooms:** There should be at least one (1) conference room identified for conduct of patient consultation, conduct of patient consenting conferences and other patient conferences.

**Waiting Room:** The waiting room space needs to be in a designated area that protects the patient from transmission of infectious agents. A reception desk could also be in this space.

**Offices/Work Space:** Space is needed for HCT/IEC attending physicians, fellow(s)/APP(s) and nurses to work. This could be a relatively large room in the dedicated HCT clinic space with individual work cubicles for the APPs, fellow(s), nurses and pharmacist to work. The attending physician should have a small private office in that same area. It is suggested that a HCT dietitian could also have a work cubicle in this space with other members of the team. A social worker should be assigned to work with the HCT/IEC patients with an office/work space area in the clinic space. There should also be a space for a dedicated scheduling person responsible for scheduling all HCT/IEC patient procedures, appointments.

**Infusion Bays:** Initially, at least one (1) identified infusion bay separated by glass walls on the sides with curtains for privacy, but open on one end for nursing observation and ease of access will be

needed in the clinic space. This one (1) infusion bay should be constructed with glass walls with curtains on all sides for isolation of a patient, particularly because there will be other non-immunosuppressed patients in the other infusion bays. The infusion bay will be utilized for administration of IV fluids, antibiotics, blood products (RBC and/or platelets) or chemotherapy infusions. A small nursing station should be located in close proximity to the infusion bays for observing and caring for these patients.

**Pharmacy:** There should be at least one (1) pharmacist dedicated to the HCT/IEC patients. The distance between this dedicated out-patient space and the hospital pharmacy or nearest satellite pharmacy will determine whether a satellite pharmacy will be needed specifically for this HCT/IEC out-patient facility. IV fluids, antibiotics, growth factors, chemotherapy and multiple oral and IV medications will be needed by the HCT/IEC patients.

**Blood Draw Space:** Near, or as part of the out-patient clinic facility, there should be a space for blood draw from the HCT/IEC patients so that these patients do not need to go to the main laboratory for blood draw. Staff in the blood draw area should be trained to access central venous access catheters which the HCT/IEC patients are likely to have in place.

**Afterhours Infusion:** HCT patients often receive IV fluids, antibiotics, blood product infusions which may extend in time after infusion room hours. A process for managing patients who require infusions after hours and on the week-end needs to be developed.

**Rapid Transport System:** A procedure for assuring rapid, safe, appropriately monitored transport of a critically ill outpatient to the inpatient unit or ICU needs to be developed.

### **Collection Facility – Bone Marrow Harvest Collection**

The Pediatric HCT Program will need to develop a Pediatric Marrow Collection Facility to perform bone marrow harvest procedure from pediatric age allogeneic donors. It will be important to work with the operating room staff to determine who will be responsible for managing equipment and supplies. In some programs the OR staff is responsible, but in other programs the processing facility is responsible for supplying reagents to be used. The OR staff would be responsible for assuring collection supplies are sterile and available for each procedure.

Coordination with the adult transplant team will be needed on the occasion when the donor selected for the pediatric recipient is an adult family member and when the donor selected for the adult recipient is a pediatric age family member. In this situation, it may be in the donor's best interest to have the adult donor cared for by the adult HCT team and to have bone marrow harvested by the adult bone marrow collection team or to have the pediatric age donor for the adult recipient be cared for by the pediatric HCT team and bone marrow harvested by the pediatric marrow collection team.

### **Collection Facility – Apheresis Collection Facility**

The adult cellular therapy program has a FACT accredited apheresis collection facility that is capable of managing the apheresis collection procedure for pediatric autologous HCT and IEC donors and pediatric

allogeneic donors. A process for clear communication between the pediatric clinical program and the apheresis facility will need to be developed.

### **Processing Facility**

The adult cellular therapy program has a FACT accredited processing facility that will be able to accommodate the additional number of pediatric cellular therapy products.

## Scope of Services

### Intake

Although not part of FACT Standards, from a practical standpoint, consideration should be given to developing a defined process for referral of a potential patient into the transplant/IEC program for consultation with a transplant/IEC attending physician to discuss HCT or IEC therapy as an option in management of the patient's specific disease or admission into the HCT/IEC program. There are a number of ways this can be accomplished. Some HCT programs have an identified transplant physician or phone number with rotating transplant physicians at that number to take all incoming calls and phone consultation regarding whether or not a patient is a potential HCT or IEC candidate. Since there is already an adult HCT/IEC program at University of Virginia and the pediatric program will be utilizing the same apheresis facility and processing facility, it would be appropriate to consider whether a single intake office or process would be beneficial for the combined adult and pediatric/IEC program.

If a patient is potentially a suitable HCT or IEC candidate, then a consult form is generated, the patient is registered into the system, demographic information is obtained, a unique patient identification number (UPN) is assigned and a determination made, depending on diagnosis, whether the patient is eligible for autologous or allogeneic HCT or IEC. If the patient is from an outside facility, medical records need to be obtained. If the patient is potentially eligible for allogeneic HCT, then a suitable donor must be identified. Donor determination begins with family HLA typing to determine if one of the siblings is HLA matched with the patient. FACT Standards require that information regarding the donation process should be provided to the potential allogeneic donor (or legally authorized representative) prior to HLA typing (FACT Standard B6.1.3). If there is not an HLA matched sibling donor, then other donor choices could be matched unrelated donor, unrelated cord blood or haploidentical family member donor.

Early in the process of considering a specific patient for HCT or IEC, financial clearance needs to be obtained. Each HCT/IEC program has a process for accomplishing this financial clearance, and this process would need to be developed for the UVA Children's Hospital. Patient financial clearance for the specific type of transplant or IEC therapy should be obtained before the patient arrives into the HCT/IEC program.

Based on preliminary patient medical information obtained by the intake physician, a determination can be made regarding the potential conditioning regimen that may be used. This will vary based on the type of HCT and patient diagnosis and may change based on initial evaluation. If the conditioning regimen is likely to include total body irradiation (TBI), then coordination of potential dates with the radiation therapy facility is needed. Once the patient arrives to the HCT program, it usually takes about 10-14 working days for the pre-transplant evaluation to be completed. If TBI is planned in the conditioning regimen, radiation therapy facility will need lead time to plan the radiation therapy and to have a linear accelerator machine available for administration of the TBI on specific day(s).

Once the date for the patient (and donor, if applicable) to arrive at the HCT/IEC program is determined, this information should be conveyed to the out-patient facility (i.e., the attending physician and HCT head nurse) so they can begin planning for the patient (and donor, if applicable) pre-transplant evaluation. Every HCT program must develop a clear way of written communication between the various sub-units within the program including Apheresis Facility and Processing Facility as well as the Clinical Facility regarding each patient so that errors do not occur.

## **Pre-transplant**

In general, all allogeneic HCT patient, all autologous HCT patient, all allogeneic HCT donor and all IEC patient evaluation and consent may be performed in the out-patient clinic. If the patient is too ill, then the pre-transplant evaluation may be performed on the in-patient unit by the inpatient HCT team. The pediatric transplant program will need to develop SOPs that detail recipient evaluation, selection and treatment, donor and recipient consent, donor screening, testing, eligibility determination, selection and management (FACT Standards B5.1.1, B5.1.3, B5.1.4).

FACT Standards contain details for allogeneic and autologous donor informed consent requirements (FACT Standard B6.2 section). The following describes the pre-transplant process.

### **Allogeneic Transplant Patient clinic visits:**

- Initial visit with APP or fellow for H&P and transplant RN for introduction to HCT
- Initial transplant conference with transplant attending physician discussion of pre-transplant evaluation, actual transplant process, risks and benefits and to sign some basic consent documents (e.g. blood transfusion, HIPAA, consent for care, etc.). It is suggested that the actual transplant consent form be given to the patient (parent) at this initial conference to review and to formulate questions before being asked to sign at the second conference after work-up complete.
- Several clinic visits for blood draw, performance BM aspiration, other procedures.
- Schedule visit with radiation oncologist if patient is to receive TBI in conditioning.
- Placement of indwelling central venous double-lumen catheter, if not already in place.
- Attending physician review of all evaluation results, confer with other attending physician regarding the related family member donor (if appropriate), conduct a second conference with the patient and parents regarding evaluation results and present details of transplant procedure and have the transplant consent form signed.
- Practices vary between different transplant centers, but the patient is usually admitted to the in-patient unit the next day after the final pre-transplant conference to begin the conditioning therapy.
- In general, this pre-transplant evaluation takes about 2 weeks.

### **Pre-transplant patient evaluation guidelines – allogeneic, autologous, syngeneic and IEC**

#### **History to include:**

- For patients with hematologic malignancies: diagnosis with attention to pathology, cytogenetics, molecular markers, extramedullary disease sites, treatment and response
- If relevant, information regarding PBSC collection and storage
- Patient exposure to steroids, chemotherapy regimens (document response), radiation therapy (total dose, duration, field) and immunotherapy
- Transfusions (include data on blood products and if irradiated)
- Current medical problems, medications and allergies
- Karnofsky or Lansky performance scores (required by CIBMTR data forms)
- Pregnancy history (females of childbearing potential)
- Vaccination history
- Tuberculosis screening

**Procedures to include:**

- Chest X-Ray and other X-Rays and/or scans as indicated
- BM aspirate and/or biopsies for pathology, flow cytometry, cytogenetics, molecular studies
- EKG on all patients and cardiac ejection fraction (MUGA or ECHO) as clinically indicated
- Oral medicine evaluation – if significant dental caries, these need to be fixed prior to HCT
- Baseline PFT (patients >6 years of age)
- LP and CSF analysis for all acute leukemia patients
- Nutritional assessment including height, weight, BSA calculation, ideal body weight and adjusted ideal body weight should be calculated and documented in patient chart.
- Gynecology consult (menstruating girls)
- Social Worker assessment as indicated
- Physical therapy evaluation of strength, flexibility and function and exercise prescription

**Laboratory Evaluation to include (all patients)**

- CBC with differential, platelet count and reticulocyte count and UA
- Comprehensive metabolic panel, triglyceride, cholesterol levels, IgG, IgM, IgA
- ABO and RH typing
- HSV, CMV, VZV serology
- Hepatitis B, Hepatitis C, anti-HIV1, 2, anti-HTLV 1 and 2
- Estradiol, FSH, HCT – menstruating girls
- LH, FSH, free testosterone (post-pubertal males)
- Vitamin D (25 Hydroxy) level
- Rectal swab to microbiology for VRE surveillance
- Nasal swab to microbiology to R/O Staphylococcus aureus and to virology for assessment of COVID-19

**Additional studies for Allogeneic Patients:**

- Toxoplasmosis serology
- Two-way red cell crossmatch between recipient and donor
- Confirmatory HLA typing of recipient and donor from independently collected sample (FACT Standard B6.4.12.2).
- HLA PRA studies, leukocytotoxic or fluorescence activated cell sorter crossmatch between recipient and donor as clinically indicated.
- Heparinized blood from recipient and donor for DNA storage for post-transplant chimerism
- CMV PCR once within 2 weeks of initiating conditioning

**Allogeneic Transplant Donor Clinic Visits (pre-donation and post-donation)**

- Initial visit with the transplant physician or APP or fellow for complete H&P. Donor evaluation must be conducted by a physician, APP or fellow familiar with the collection procedure who is NOT the primary health care professional overseeing care of the recipient (FACT Standard B6.2.6.1)
- Informed consent of a donor who is a minor must be obtained from the donor's legally authorized representative and shall be documented (FACT Standard B7.2.7)/
- Various clinic visits to complete Donor History Questionnaire, blood draw and procedures

- If donor is to undergo bone marrow harvest, then anesthesiology visit is needed to evaluate the donor per ASA criteria.
- If donor is to undergo apheresis for collection of PBSC, peripheral venous access must be evaluated by Apheresis Facility RN. If this assessment determines that peripheral venous access is not adequate, then arrangements need to be made for insertion of a temporary central venous catheter.
- Updated abbreviated H&P needed within five (5) days of initiating collection (marrow or PBSC)
- If donor is to have PBSC collected by apheresis, 5 daily clinic visits for administration of G-CSF for mobilization of stem cells. This must be timed so that the day of PBSC collection will be day -1 related to the recipient transplant. Another PBSC collection from the donor will often be needed on Day 0 (the designated transplant day) as well. The donor has PBSC collected in the Apheresis Facility and should be evaluated and cared for by the professional caring for the donor. Depending on the number of cells ordered to be collected (usually measured by CD34+ cell count), the donor may need to receive an additional dose of G-CSF for repeat collection the following day (i.e., Day 0).
- If the donor is to have bone marrow harvested for transplant, the bone marrow donor is admitted to surgery on Day 0, the marrow harvest performed by the marrow harvest transplant physician and APP or fellow. The donor can usually be discharged following recovery from anesthesia.
- Donor follow-up – the Pediatric Clinical Program will need to develop a policy for follow-up of the donor that includes routine management and management of collection associated adverse events (FACT Standard B6.3.9). Most transplant programs will have the donor (marrow or apheresis donor) seen in the transplant clinic by the transplant professional responsible for the donor, one- or two-days following donation. At this evaluation CBC with differential and platelet count will be obtained. Marrow harvest sites will be assessed, if appropriate. The apheresis donor who has a temporary central venous catheter placed for cell collection will need to have this catheter removed 5-6 hours after final collection is completed.

### **Donor – Allogeneic Bone Marrow and Peripheral Blood Stem Cells Evaluation**

The donor must be evaluated for both risk to the donor of the collection procedure and the risk to the recipient for transfusion transmitted diseases.

Protection of the Donor: Bone Marrow Harvest – major risks involve use of anesthesia and loss of blood volume. Apheresis Collection – major risks involve potential reaction to solutions or medications administered for collection, e.g., anticoagulants and filgrastim (G-CSF) for mobilization and loss of specific blood cells e.g., temporary lower platelet count. Donor with history of heparin allergy, heparin intolerance, heparin induced thrombocytopenia (HIT) or on therapeutic anticoagulation are at risk for complications with collection procedure using heparin.

Protection of the Recipient: Strict guidelines and Federal Regulations regarding the evaluation of the blood donor have been developed, and compliance with these regulations and guidelines is expected for the bone marrow or stem cell donor. Exception is possible if (1) there is no other appropriate donor and the proposed donor poses less risk to the recipient than not using the donor, (2) recipient approval is obtained only after the donor has given permission to have health information released to the recipient (FACT Standard B6.2.8).

### Allogeneic Donor Evaluation Procedures:

- Donor Screening Questionnaire must meet FDA regulations for evaluation of HPC donor. Donor evaluation includes risk factor screening by health history questionnaires, review of medical records, physical examination, and testing for relevant communicable diseases. The donor is determined to be eligible if he/she is (1) free from risk factors for and clinical evidence of relevant communicable diseases, (2) free from communicable disease risks associated with xenotransplantation, and (3) tests negative or non-reactive for relevant communicable diseases agents within the specified timeframe for the product. It is the responsibility of the Clinical Program to document that donor evaluation procedures are in place to protect the recipient from the risk of disease transmission from the donor. (FACT Standard B6.4.5)
- Comprehensive H&P shall include (FACT Standard B6.4.6)
  - Blood transfusions
  - Vaccination history
  - History of heparin allergy, heparin intolerance, HIT, therapeutic anticoagulation (PBSC donors only)
  - Previous anesthetic exposure experience (Bone Marrow Donors)
  - Travel history
  - Questions to identify persons at risk of transmitting inherited conditions
  - Questions to identify past history of malignant disease
  - Possibility of pregnancy must be determined for all female donors of childbearing potential
- Procedures include:
  - Vascular access assessment for all related apheresis donors (performed by Apheresis RN)
  - EKG for donors with history of diabetes, cardiovascular disease, pulmonary disease, older than 40 years (males) or 50 years (females)
  - Chest X-Ray for donor with history of pulmonary disease or positive PPD
  - Oxygen saturation for bone marrow donor
- Documentation of Donor Suitability (Donor medical risk) and Eligibility (Recipient infectious disease risk)
  - Donor attending physician must meet with the donor to review evaluation results and document in the donor chart that the donor is suitable – not put at medical risk by the donation process. This review of donor health and consent will be separate from review of the recipient health and consent to protect both donor and recipient confidentiality.
  - Donor attending physician completes Donor Eligibility Declaration, declaring the donor is either Eligible or Ineligible based on the presence or absence of risk of communicable disease transmission to the recipient. (FACT Standard B6.4.13) This Donor Eligibility Declaration form will need to be developed by the Pediatric Clinical Program. Donor Eligibility shall be documented in the recipient's medical record before the recipient's conditioning regimen is begun. Use of an ineligible allogeneic donor, or an allogeneic donor for whom donor eligibility determination is incomplete shall require documentation of the rationale for donor selection by the transplant physician, urgent medical need documentation and the informed consent of the donor and recipient (FACT Standard B6.4.15). Allogeneic donor eligibility shall be communicated in writing to

the Collection and Processing Facilities (FACT Standard B6.4.16). Allogeneic donor records shall include donor eligibility determination, including the name of the responsible person who made the determination and the date of the determination (FACT Standard B6.4.17.1).

- Laboratory studies shall include:
  - CBC with differential, platelet and reticulocyte count
  - Comprehensive metabolic panel
  - ABO, Rh typing, antibody screening and two-way RBC crossmatch with recipient
  - HLA A, B, and DRB1 type for all allogeneic donors and HLA-C for unrelated allogeneic donors and related allogeneic donors other than matched sibling. DNA high resolution typing used for DRB1 typing. Verification typing on selected allogeneic donor using independently collected sample confirmed prior to condition regimen administration (FACT Standard B6.4.12).
  - Anti-HLA antibody testing for mismatched donors and recipients (FACT Standard B6.4.12.4)
  - SOP to confirm the identity of cord blood units if verification typing cannot be performed on attached segments (FACT Standard B6.4.12.3).
  - Heparinized blood from recipient and donor for DNA storage to be used post-transplant for chimerism evaluation (determination of engraftment of donor cells).
  - Infectious disease testing for HIV type 1 and 2, Hepatitis B, Hepatitis C, syphilis, HTLV-1 and 2, West Nile virus, Trypanosoma cruzi, CMV done within timeframes required by applicable law and regulations (FACT Standard B6.4.7).
  - Tuberculosis testing as clinically indicated
  - Sickle cell testing as clinically indicated or for all donors receiving B-CSF for mobilization.

#### **Autologous Transplant Patient Visits Pre-Transplant**

- Initial conference with attending physician and APP or fellow for H&P, and for the attending to outline the procedures to be performed for evaluation and discussion of the autologous transplant process to include discussion of administration of mobilizing agent (e.g., G-CSF), the apheresis collection procedure and signing of the consent for leukapheresis, blood transfusion, HIPAA, storage contract and consent for treatment.
- Tumor staging studies (CT, MRI, PET scans) for solid tumor patients
- May require BM biopsy in addition to BM aspirate
- Visit with Apheresis Facility for vein check if plan to have peripheral vein used for the procedure or to have type of indwelling central venous catheter checked for adequacy for collection procedure as some central venous catheters are too small diameter to allow for adequate blood flow for collection.
- Scheduling for apheresis procedure for collection of cellular therapy product before transplant is scheduled. Once date(s) for apheresis scheduled, then outpatient clinic staff will need to administer mobilizing agent (e.g. G-CSF) for several days prior to collection. A process will need to be in place for CD34+ cell count after the first day of collection to determine whether a second day of collection needed and plan for administration of mobilizing agent.

## **Autologous Cellular Therapy Collection Evaluation**

The patient undergoing autologous collection and storage of PBSC must be evaluated for risks involved with the donation procedure

Protection of the Autologous Patient: Major potential risk is the transient extracorporeal blood volume deficit during the apheresis procedure, the loss of specific blood cells (usually platelets) and the potential reaction to solutions or medications administered for the collection (anticoagulants and filgrastim (G-CSF) or chemotherapy). Small donors will likely need to have the apheresis machine primed with allogeneic, CMV appropriate, irradiated red blood cells to permit the small donor to tolerate the extracorporeal blood volume. Donors with a history of heparin allergy, heparin intolerance and HIT or on therapeutic anticoagulation are at risk for complications with collection using heparin. The apheresis procedure may reduce the platelet count by 30-50% so that donors who are receiving therapeutic anticoagulation or donors with low platelet counts pre-donation must be evaluated after each apheresis collection procedure to determine the need for platelet transfusion.

### **Autologous Patient Evaluation Procedures:**

- **Comprehensive H&P to include:**
  - Blood transfusions
  - Vaccination history
  - History of heparin allergy, heparin intolerance, HIT, therapeutic anticoagulation
  - Travel History
  - Infectious disease risks
  - Possibility of pregnancy must be determined for all female donors of childbearing potential
- **Laboratory studies shall include:**
  - CBC with differential, platelet and reticulocyte count
  - Comprehensive metabolic panel
  - ABO, Rh typing and antibody screening
  - Infections disease testing for HIV type 1 and 2, Hepatitis B, Hepatitis C, syphilis, HTLV-1 and -2, West Nile virus, Trypanosoma cruzi, CMV
  - Tuberculosis testing as clinically indicated
  - Sickle cell testing for all donors receiving G-CSF for mobilization
  - Female donors of childbearing potential: Serum HCG
- **Other Procedures**
  - Staging work-up for autologous donor's underlying malignant disease
  - Chest X-Ray as clinically indicated
  - UA

### **IEC patient**

Similar to allogeneic and autologous patient evaluation except:

- Initial conference will include discussion of the goals of immune effector therapy, potential risks and benefits, collection of the cells by apheresis, manufacture of the T-cell product, potential need for bridging therapy while the T-cell product is being manufactured and the treatment chemotherapy for lymphodepletion prior to infusion of the T-cell product. Depending on the

protocol being used, a separate consent for leukapheresis procedure may be signed at this conference or the protocol consent form may include the pre-treatment evaluation, leukapheresis, bridging chemotherapy, IEC treatment procedure. The IEC team will need to determine which is appropriate for the particular patient.

- Visit with Apheresis personnel for venous access check to ensure venous access appropriate for the procedure.
- Plans for IEC patient follow-up after apheresis and before IEC therapy scheduled to begin.

**Peripheral Blood Stem Cell Collection by Apheresis:** For Standard volume leukapheresis (i.e., 12 liters or 3 times total blood volume) the patient should have Hematocrit >30% and Platelet count >20,000/ $l^3$

- Before initiation of apheresis there shall be peripheral blood count criteria to proceed with collection (FACT Standard C8.8)
- Allogeneic blood components administered to the donor during apheresis collection should be CMV appropriate and irradiated (FACT Standard C8.5).
- Before collection is undertaken, there shall be a written order from a physician specifying, at a minimum, timing and goals of collection (FACT Standard C8.6).
- A CBC and platelet count shall be performed within 24 hours prior to each subsequent cellular therapy product collection by apheresis (FACT Standard C8.7).
- There shall be written documentation of an assessment of donor suitability for the collection procedure performed by qualified person immediately prior to each collection procedure (FACT Standard C8.9).
- All collected autologous cellular therapy products are labeled and transported to the Processing Facility for processing and cryopreservation prior to initiating the transplant conditioning regimen (autologous transplant) or transporting to manufacturing facility (IEC therapy).

## Transplant

**Transplant Conditioning:** The conditioning regimen, administered immediately prior to the infusion of the cellular therapy product for transplant, is designed to provide tumor reduction or eradication and sufficient immunosuppression to enable engraftment of allogeneic donor cells.

Conditioning regimens are designed to be disease specific. The Pediatric Medical Director and other pediatric transplant physicians will need to develop the transplant protocols or disease specific standard treatment plans along with protocol specific or standard treatment plan specific patient consent forms. All clinical trials and clinical research protocols and consent forms will require institutional IRB approval. Some institutions do not require standard treatment plans and consent forms to be IRB approved and others do. Written protocol documents or standard treatment plan documents are important for detailing background, objectives, patient eligibility and exclusion, patient evaluation, conditioning regimen, graft-versus-host-disease (GVHD) prophylaxis medications (allogeneic patients) and post-transplant evaluations. Conditioning regimens may be myeloablative, reduced intensity or non-myeloablative. The type and details of the conditioning regimen and the type of protocols or standard treatment plans will be determined by the Pediatric Transplant program Medical Director. Since there is an already established adult HCT program, some of the protocols or standard treatment plans that are already developed may be appropriate for inclusion of pediatric patients.

The pediatric transplant program will need to develop a policy addressing the safe administration of the conditioning regimen (FACT Standard B7.4). The treatment orders need to include the patient height and weight, specific dates, dose and route of administration of each agent. These orders should be preprinted or the electronic equivalent which need to be verified and documented by an attending physician (FACT Standard B7.4.1, B7.4.2). The pharmacist preparing the drug shall verify and document the dose against the protocol or standard treatment plan regimen listed on the orders (FACT Standard B7.4.3). Prior to administration of the conditioning regimen, one (1) qualified person using a validated process shall verify and document the drug and dose in the bag or pill against the orders and the protocol and the identity of the patient to receive the therapy (FACT Standard B7.4.4).

Some conditioning regimens include the use of TBI. The transplant program will need to develop a policy addressing the safe administration of radiation therapy (FACT Standard B7.5). There shall be consultation with a radiation oncologist prior to initiation of TBI (FACT Standard B7.5.1). The patient diagnosis, relevant medical history including pre-existing co-morbid conditions and proposed conditioning regimen shall be made available to the radiation oncologist in writing (FACT Standard B7.5.2). A documented consultation by the radiation oncologist shall address any prior radiation treatment the patient may have received and other factors that may increase the toxicity of the irradiation and include a plan for delivery of TBI. Prior to administration of each dose of radiation therapy, the dose shall be verified and documented as per radiation therapy standards. A final report of the details of radiation therapy administered shall be documented in the patient medical record. (FACT Standards B7.5.4, B7.5.5).

**Transplant Day:** The day of infusion of the cellular therapy product (transplant) is always referred to as Day 0. Under no circumstances are these cells to be irradiated. The pediatric transplant program will need to develop a policy addressing the safe administration of cellular therapy products (FACT Standard B7.8). There shall be a policy for determining the appropriate volume and appropriate dose of red blood cells, cryoprotectants and other additives (FACT Standard B7.7.1). There shall be a policy for volume of ABO incompatible red cells in allogeneic cellular therapy products (FACT Standard B7.6.2). There shall be consultation with the Processing Facility regarding cord blood preparation for administration (B7.6.3). Two (2) qualified persons shall verify the identity of the recipient and the product and the order for administration of the product prior to the administration of the cellular therapy product (FACT Standard B7.6.4). There shall be documentation in the recipient medical record of the administration of the cellular therapy product unique identifier, initiation and completion times of administration and any adverse events related to administration (FACT Standard B7.6.6). A circular of information for cellular therapy products shall be available to staff (FACT Standard B7.6.7).

Intra-program communication and coordination is required. For the autologous transplant patient, the PBSC will have been collected and cryopreserved prior to administration of the conditioning regimen. On Day 0, coordination with the Processing Facility is needed for transport of the cryopreserved cells to the patient bedside, thawing of the cells at the patient bedside and infusion of the cells into the patient by a nurse trained in administration of the cellular therapy product according to the developed policy for infusion of cryopreserved apheresis PBSC. Allogeneic donor PBSC or bone marrow are almost always collected the day before (Day -1) and/or on Day 0 and are administered fresh to the patient. These freshly collected cells are usually sent to the Processing Facility for final labeling, cell counts and any cell manipulation such as RBC or Plasma depletion prior to being delivered to the

patient for administration by a nurse training in the administration of this cellular therapy product according to the policy for infusion of fresh marrow or PBSC

### **Post-Transplant – Post-IEC Therapy**

**Autologous Transplant Patients;** These patients are at risk for development of infections (bacterial, viral, fungal), particularly during the period of absolute neutropenia (16-20 days) before the patient achieves a sustained granulocyte count  $>500$  neutrophils/mm<sup>3</sup>. The transplant program should develop a policy for infection monitoring, infection prevention and infection management with the infectious disease team. Once the patient's peripheral blood counts have recovered sufficiently and the patient has recovered from the acute toxicities of the conditioning regimen, the patient may be able to be followed closely as an out-patient. Follow-up in the out-patient area may be as long as needed, but the program shall develop a policy or SOP for planned discharges to the primary care oncologist for provision of further post-transplant care (FACT Standard B7.8). When the patient is eating and drinking adequately and is off most medications (usually 30-60 days post-HCT) the patient may then be referred back to their primary care oncologist. The Clinical Program shall provide appropriate instructions to autologous patients prior to discharge (FACT Standard B7.8.2). The Clinical Program needs to develop an infrastructure and policies or SOPs for provision of appropriate long-term follow-up, treatment and plans of care (FACT Standard B7.12).

**IEC Therapy Patients:** There shall be regular assessment of the IEC recipient to detect complications, including cytokine release syndrome and neurologic dysfunction. There shall be a written plan for rapid escalation of care, increase intensity of monitoring and relevant workup to address complications. Communication to the clinical staff, intensive care unit, emergency department and pharmacy shall be timely. The Clinical Program shall have written guidelines for management of complications, including the use of cytokine-blocking agents and corticosteroid administration (FACT Standard B7.11).

**Allogeneic Patients:** these patients are at risk for significant mucositis (depending on conditioning regimen), infections (bacterial, fungal, viral), GVHD, severe liver toxicity, renal toxicity, hypertension, interstitial pneumonia and transient diabetes related to steroid therapy. It is recommended that all allogeneic patients remain under the care of the transplant team for a minimum of 100 days after HCT.

SOPs are required for management of the following: (FACT Standard B7.7)

- Nausea, vomiting, pain and other discomforts
- Monitoring of blood counts and transfusion of blood products
- Monitoring of infections and use of antimicrobials, antifungal agents, antiviral agents
- Monitoring of organ dysfunction or failure and institution of treatment
- Monitoring of graft failure and institution of treatment
- Regular assessment for acute GVHD using established staging and grading systems
- Regular assessment for chronic GVHD using established staging and grading system

#### Infections:

Pneumocystis jiroveci: All patients must receive medication to prevent Pneumocystis jiroveci pneumonia which is potentially fatal and occurs primarily in immunocompromised patients.

Bacterial infections: some transplant programs administer prophylactic antibiotics to help prevent bacterial infections and others do not.

Fungal infections: prophylactic antifungal therapy may be indicated in patients whose probability of fungal infections approximates 10% or greater. Prophylactic fluconazole is administered by many transplant programs through Day +75.

Herpes Simplex and Varicella Zoster Virus: patients who are seropositive for HSV and/or VZV are at greatest risk for infection via reactivation of endogenous virus. Antiviral prophylaxis with acyclovir is recommended for seropositive patients. Valacyclovir is preferred for patients receiving steroids. Prophylactic therapy is continued for 1 year or longer in those receiving continued immunosuppression.

CMV prevention: among CMV seropositive allogeneic HCT patients, 70% develop CMV reactivation and 35-40% develop CMV disease without preemptive therapy. Among seronegative recipients with a seropositive donor, 20% develop reactivation and 10% develop disease. With use of preemptive therapy, the incidence of CMV disease has been reduced to <5% during the first 100 days.

#### Graft-versus-Host Disease (GVHD)

- Without exception, all allogeneic transplant recipients must receive prophylactic immunosuppression to prevent development of acute GVHD.
- There are a number of different immunosuppressive regimens which may be used that frequently involve use of calcineurin inhibitor (cyclosporine or tacrolimus) combined with other agents. The Clinical Program will need to determine which regimen to use for specific transplant types including recipients of matched sibling donor, unrelated donor, cord blood.
- Regular assessment of acute GVHD stage and grading is needed and should be documented in the medical record. Treatment plans need to be developed for those developing acute GVHD.
- Assessment of patients for evidence of chronic GVHD is needed and should be documented in the patient's medical record. Treatment plans for chronic GVHD need to be developed.

#### Engraftment

- Daily CBC and platelet count until granulocyte count reaches and is maintained  $>500\text{cells}/\text{mm}^3$
- Bone marrow examination at Day +28 and Day +100 for pathology, flow cytometry, cytogenetics and other studies as clinically indicated
- Peripheral blood chimerism testing for CD3 and CD33 (T cells and myeloid cells). The Clinical Program will determine the method to be used which may be by fluorescence activated cell sorting (FACS) or DNA based assay for short tandem repeat loci. Determination of chimerism is necessary to assure complete or partial engraftment. Time of chimerism testing with peripheral blood to be determined, but is suggested at Day +28 and Day +80, at time of disease relapse (if this occurs) and in patients with post-transplant recurrent neutropenia of uncertain etiology.

#### Post-transplant Allogeneic Departure Evaluation:

- Evaluation between Day +80-+100 is important to assess disease status, engraftment status, chronic GVHD, and other treatment related complications. This evaluation is helpful to provide long-term post-HCT continuity of care, especially for the patient who is being discharged to the care of their primary care hematologist/oncologist.
- If the patient has chronic GVHD, prolonged treatment with one or more immunosuppressive agents is necessary for untreated chronic GVHD may be severely disabling or fatal. The Pediatric Clinical Program Director will need to develop protocols or treatment plans for management of these patients. Chronic GVHD patients may be managed by the transplant team directly or they may be available to assist the primary care physician in management of these patients.

Long-term Follow-up (LTFU) for all patients (Allogeneic, Autologous, IEC)

- There shall be an infrastructure and SOPs in place for provision of appropriate LTFU, treatment and plans of care (FACT Standard B7.12)
- There shall be SOPs for monitoring by appropriate specialists of recipients for post-cellular therapy late effects including, at a minimum:
  - Endocrine and reproductive functions and osteoporosis
  - Cardiovascular risk factors
  - Respiratory function
  - Chronic renal impairment
  - Secondary malignancies
  - Growth and development of pediatric recipients
- There shall be SOPs describing acceptance of pediatric recipients into LTFU clinic for adults (FACT Standard B7.12.2.1)
- There shall be SOPs in place for post-transplant vaccination schedules and indications (FACT Standard B7.9)

## Staffing

### Physicians:

- Suggest a minimum of two (2), but preferably three (3) dedicated transplant attending physicians, including the Pediatric Clinical program Director. One attending physician for the in-patient unit and one attending physician for the out-patient clinic. One physician to oversee the Apheresis Facility when children are undergoing apheresis and be responsible for the intake office for new patient referrals and organizing the transplant/IEC schedules.
  - Some transplant programs have one transplant physician assigned to a specific patient and that physician follows and cares for the patient through all their transplant course. Other transplant programs have physicians assigned to cover specific areas (in-patient, out-patient, intake) with monthly or other frequency rotating schedule.
  - The Pediatric Clinical Program Director will determine the type of care schedule for the program.
- The Pediatric Clinical Program Director shall be a physician with specialist certification In Pediatric Hematology/Oncology or Pediatric Immunology and have at a minimum two (2) years' experience as an attending physician responsible for the direct clinical management of HCT transplant patients in the in-patient and out-patient settings. This individual is responsible for all elements of the design of the Clinical Program including quality management, selection and care of patients and cell collection and processing. The Clinical Program Director is responsible for verifying their knowledge and skills for members of the Clinical Program annually. The Clinical Program Director shall participate in ten (10) hours of educational activities related to cellular therapy annually (FACT Standards B 3.1.1 – B3.1.6).
- Attending Physicians should be specialist certified in Pediatric Hematology/Oncology or Pediatric Immunology. These physicians shall participate in ten (10) hours of continuing education activities related to cellular therapy annually. They shall have a minimum of one (1) year supervised training in the management of transplant patients both in-patient and out-patient.

### Primary Care Providers

The care and management of the in-patient and out-patient transplant/IEC patients requires not only the attending physician, but also a primary care provider. There should be at least one (1) primary care provider for the out-patient clinics and one (1) primary care provider for the in-patient unit. Transplant programs utilize fellows-in-training and advance practice providers (APPs including PA-Cs and nurse practitioners) to fulfill this role.

- **Fellows:** Part of the fellowship training program includes learning HCT and working with HCT attending physicians and patients. These physicians shall receive specific training and develop competence in transplant-related skills, including those listed in FACT Standard B3.3.4, B3.3.5.
- **Advanced Practice Providers (APPs):** The APPs shall be licensed to practice in the jurisdiction of the Clinical Program and shall be limited to a scope of practice within the parameters of their training and licenses. They shall have received specific training and maintain competency in the transplant-related skills that they routinely practice, include those listed in FACT Standards B3.3.4 and B3.3.5. APPs shall participate in ten (10) hours of educational activities related to cellular therapy annually. Given the anticipated size of the Pediatric HEC/IEC program anticipated, 2-3 APPs should be sufficient to cover the in-patient and out-patients services.

## **Nurses:**

- The Clinical Program shall have nurses formally trained and experienced in the management of pediatric patients receiving cellular therapy. For the in-patient unit a ratio of RN to patient is usually 1:2 for the day shift and 1:3-4 for the night shift. For the out-patient clinic, usually one (1) RN can manage 12-15 patients, but it is suggested that there be two (2) out-patient RNs for the out-patient clinic transplant team.
- For the Infusion suite, the RN to patient ratio is 1:1 for chemotherapy administration for several hours. For the infusion of blood, IV fluids, antibiotics the RN to patient ratio is usually 1:3.
- Nursing training and competency shall include (FACT Standard B 3.7.3):
  - Hematology/Oncology patient care, including an overview of cellular therapy process
  - Administration of conditioning/lymphodepletion regimens
  - Administration of blood products, growth factors, cellular therapy products and other supportive therapies
  - Care interventions to manage cellular therapy complications including cytokine release syndrome, tumor lysis syndrome, cardiac dysfunction, respiratory distress, neurologic toxicity, macrophage activation syndrome, renal and hepatic failure, anaphylaxis, neutropenic fever, nausea, vomiting, mucositis, pain management.
  - Recognition of cellular therapy complications and emergencies requiring rapid notification of the transplant team
  - Palliative and end of life care
- Written policies for all relevant nursing procedures (FACT Standard B3.7.4)
  - Care of immunocompromised recipients
  - Administration of condition regimens
  - Administration of cellular therapy products
  - Administration of blood products
  - Central venous access device care
  - Detection and management of IEC therapy complications

## **Pharmacists**

- Pharmacists shall be licensed to practice in the jurisdiction of the Clinical Program and shall be limited to a scope of practice within the parameters of their training and licensure.
- Training and knowledge of designated pharmacists shall include (FACT Standard B3.8.2)
  - Hematology/oncology patient care, including the process of cellular therapy
  - Adverse events, including cytokine release syndrome and neurologic toxicities
  - Therapeutic drug monitoring, including anti-infective agents, immunosuppressive agents, anti-seizure medications and anticoagulants
  - Monitoring for and recognition of drug/drug and drug/food interactions and necessary dose modifications
  - Recognition of medications that require adjustments for organ dysfunction
- Designated pharmacists shall be involved in the development and implementation of controlled documents related to the pharmaceutical management of cellular therapy recipients
- Designated pharmacists shall participate in a minimum of ten (10) hours of educational activities related to cellular therapy annually.

### **Support Services Staff:** FACT Standard B 3.11)

- The Clinical Program shall have one (1) or more designated staff with appropriate training and education to assist in the provision of pre-transplant recipient evaluation, treatment and post-transplant follow-up and care. Designated staff shall include:
  - Dietary Staff: to provide dietary consultation regarding the nutritional needs of the recipient including enteral and parenteral support and appropriate dietary advice to avoid food-borne illness. Suggest one dedicated dietitian for the transplant team.
  - Social Services Staff: suggest at least one (1) dedicated social worker for the transplant team
  - Physical Therapy Staff: all transplant/IEC patients need to have physical therapy, particularly those patients who spend several weeks in bed and those receiving steroid therapy to assist with maintain strength and mobility.
  - Data Management Staff: data management staff sufficient to collect all data necessary to complete and submit the CIBMTR data forms recommended for all autologous patients and IEC recipients. At least one (1) data management staff individual will be needed to work with adult data management staff to be able to complete all CIBMTR data forms for the combined adult/pediatric cellular therapy program.

### **Quality Manager**

- There shall be a Pediatric Clinical Program Quality Manager to establish and maintain systems to revise, modify, and approve all policies and SOPs intended to monitor compliance with FACT Standards or performance of the Clinical Program (FACT Standard B3.10.1)
- Each operational unit within the Pediatric Clinical Program (Collection Bone Marrow) must have a designated quality specialist with sufficient expertise to oversee the quality program in their area, and who does not have oversight over their own work. The quality specialist may be shared with other programs, but should be knowledgeable in their area and well versed in all aspects and documents involved in the program operation such that they can present the quality activities to anyone in their program.
- A combined (adult and pediatric) cellular therapy program may, but is not required, to have one Quality Management Plan that addresses all aspects of the Clinical, Collection and Processing Facilities. If managed across organizational boundaries, there must be clear evidence of relationships among Quality management Programs. Relationships and interactions among Quality managers and representatives in the different organizations should be explicit to underpin cohesion within the overall cellular therapy program. There must be a mechanism for communication of information and sharing of quality data among key elements of the program.
- The Pediatric Clinical Program needs to determine how they are going to establish their Quality Management program.
- Pediatric Clinical Program Quality Manager, Apheresis Collection Facility Quality Manager and Processing Facility Quality Manager shall participate in ten (10) hours of educational activities related to cellular therapy and/or quality management annually.

## **Bone Marrow Harvest Facility**

The Pediatric Marrow Collection Facility shall have a Marrow Collection Facility Medical Director, a Quality Manager and a minimum of one (1) additional designated staff member. This team shall have been in place and performing cellular therapy product collections for at least twelve (12) months preceding initial accreditation (Standard CM 1.4)

- A minimum of one (1) marrow collection procedure shall have been performed in the twelve (12) month period preceding initial accreditation, and a minimum average of one (1) marrow collection procedure per year shall be performed within each accreditation cycle.
  - Programs performing both adult and pediatric marrow collection may collect from adult donors in one facility and pediatric donors in another. If different individuals perform collection in each of the sites, then both sites must perform a minimum average of one (1) collection per year within each accreditation cycle (Standard CM 1.5)
- There shall be appropriate designated areas for collection of cellular therapy products, for collected products, and for storage of equipment, supplies and reagents. (Standard CM2.1)
  - There shall be suitable space for confidential donor examination and evaluation.
- There shall be adequate equipment and materials for procedures performed. Standard CM 2.6)

## **Marrow Collection Medical Director**

### **Responsibilities**

- all technical procedures and performance of marrow collection procedure
- for staff supervision and administrative operations
- medical care of allogeneic and autologous donors undergoing marrow collection
- pre-collection evaluation of allogeneic and autologous donors at the time of donation
- care of any complications resulting from collection procedure
- Quality Management Program

### **Qualifications**

- At least two (2) years' experience in cellular therapy product collection procedures
- Have performed or supervised ten (10) marrow collection procedures within his/her career
- Ten (10) hours educational activity related to cellular therapy annually

### **Quality Manager**

- Establish and maintain systems to review, modify, and approve all policies and SOPs to monitor compliance with performance of Marrow Collection Facility
- Participate in ten (10) hours educational activities related to cellular therapy, cell collection and quality management annually.

### **Staff**

- Physicians and collection staff shall have documented training and experience with pediatric donors
- Number of trained collection personnel shall be adequate for the number of procedures performed and shall include a minimum of one (1) designated trained individual with identified trained backup to maintain sufficient coverage.

### **Licensure, Proficiency, Regulatory Requirements**

- Virginia Department of health license for new facility
- Federal Wide Assurance (FWA) filed with Office of Human Research Protection (OHRP)
- The Joint Commission Accreditation – need to know when they will notify UVA Children’s Hospital for initial survey
- FDA registration of processing laboratory (testing labs in the same institution are automatically registered at the same time, such as microbiology, flow cytometry and apheresis) – this may already be done, but not sure if UVA Children’s included.
- CIBMTR – for reporting allogenic transplants and recommended for autologous and IEC therapy recipients. The CIBMTR already receives data from the adult program, but need to check with them about the addition of the Pediatric program.
- FACT Accreditation – as the pediatric program plans to be added to the already FACT accredited adult program, the pediatric cellular therapy program designated transplant team must have been in place for 12 months preceding initial accreditation application and performing the minimum number of 5 pediatric allogeneic transplants in the preceding 12 months and then maintain an average of 5 pediatric allogeneic transplants per year within the accreditation cycle (3 years). If the Pediatric Cellular Therapy Program is not ready for initial accreditation inspection until mid-adult program accreditation cycle, the pediatric program may be added at that time and then be reinspected at the time the adult program next accreditation reinspection would occur.
- Participation in CAP proficiency for CD34 evaluation, hematology, microbiology parameters is universally used to demonstrate adequacy of laboratory testing. If the Pediatric cellular therapy program will be using the laboratory already CAP approved for performing CD34 evaluation, this may not be needed, but if a different laboratory will be used by the Pediatric program, the CAP proficiency for CD34 evaluation will be needed.

### **Contracts**

If laboratories outside of UVA Children’s Hospital are required for performance of some tests, then contracts are needed that describe the responsibilities of each facility with respect to the particular process involved. Review contracts already established by the Adult Cellular Therapy Program with the commercial CAR-T cell companies to determine if additions or revisions are needed for providing this service for the Pediatric IEC program. Interactions with all contracted vendors must be covered by the Quality Management Program and must include supplier qualification, annual audits and contract review on a regular basis.

## Business Development Initiatives

The development of a business plan for the economic success of the newly developed Pediatric Cellular Therapy Program (Transplant and IEC) is unique to the specific organization and is dependent on the payor mix and the contracts negotiated with the various payors. Published data from the Agency for Healthcare Research and Quality found that HCT is relatively uncommon, but is among the top 10 procedures with the highest increase in hospital costs in the 2004-2007 time period in the U.S.<sup>2</sup> A study was done using claims data from Thomson Reuters MarketScan, a single longitudinal database of administrative private insurance claims of patients distributed in the US to establish a cohort of autologous and allogeneic HCT recipients.<sup>1</sup> Direct medical costs over the first 100 days post-transplant were described. These costs included the initial transplant hospitalization, any subsequent hospitalizations, cost associated with out-patient visits and treatment. Cost estimates were based on the amount paid of adjusted claims including insurance and health plan payments. The median 100-day costs for autologous HCT were \$99,899 (range \$73,914-\$140,555), but costs were \$100,000-\$200,000 for patients <20 years of age. Median 100-day costs for allogeneic recipients were \$203,026, but median costs were \$302,822 for recipients <20 years of age. Not included in this analysis were expenses the patients incurred with respect to co-payments and deductibles or costs for non-medical expenses such as transportation, lodging and lost income. Studies evaluating the costs and cost-effectiveness of CAR-T cell therapy are being done, but are inconclusive at this time.<sup>4,5</sup>

Costs of commercial CAR-T cells vary depending on manufacturer of the product. Ranges between \$300,000 - \$400,000 have been described. Information presented at the 2019 ASTCT meeting indicated that both Kymriah (Novartis) and Yescarta (Kite) anti-CD-19 CAR-T products cost about the same. Most commercial insurance covers this. There may be limitations for other specific insurance plans and employer-based insurance plans. Refer to the ASTCT website under Practice Resources for CPT Coding presentation detailing other aspects of this and how CMS is covering CAR-T cell treatments.

Cost recovery is dependent on coding for various transplant-related procedures and allowable charges. ASTC provides information about this aspect of operation through their Committee on BMT Coding and Reimbursement. ASTCT also has CAR-T therapy reimbursement resources including CAR-T collection and Cell Processing Coding Options, CAR-T Product Coding Options, CAR-T Administration Coding Options and others. This group also has developed coding recommendations for CAR-T cells.

It will be important to connect with the medical directors of the major insurance companies used by the patients at UVA Children's Hospital to discuss with them the development of the new Transplant and IEC Program. Working with these medical directors prospectively will be important regarding the development of payment plans for the initial transplant patients before FACT Accreditation is achieved. Consider emphasizing to payors that this new pediatric cellular therapy program is to be part of the FACT Accredited Adult Cellular Therapy Program at the University of Virginia and that the Apheresis Collection Facility and Processing Facility that the Pediatric Program will be utilizing are already FACT Accredited.

Marketing of the new Pediatric Transplant and IEC program should include education of hospital consultant staff members as well as the private pediatric physicians who will be referring patients and also education of community members. Outreach activities should be ongoing to reinforce the new Pediatric Transplant and IEC Therapy program.

Budgetary items will include hiring of additional staff, including a data manager and APPs and perhaps additional equipment and reagents for marrow harvest collection.

Consideration of housing for out-patients and caregivers is needed. Separate apartments for patients and family members have advantages over communal living spaces, such as Ronald McDonald House. Allogeneic transplant recipients should be followed by the transplant team for 100 days after transplant and IEC patients are required to be cared for by the transplant team for a minimum of 28 days after IEC therapy administration. Pre-transplant and IEC therapy time will range from 206 weeks.

## Resources

- [CIBMTR.org](http://CIBMTR.org)
- [ASTCT.org](http://ASTCT.org)
- [Celltherapysociety.org](http://Celltherapysociety.org) for ISCT

The CIBMTR and ASTCT websites contain transplant information that will be helpful to developing program. The annual TCT meeting in February has educational programs for physicians, nurses, pharmacists, data managers, quality managers and APPs. Information regarding the meeting can be found on the ASTCT and CIBMTR websites. The meeting is always in February and in the US

- [Factwebsite.org](http://Factwebsite.org)
  - 7<sup>th</sup> Edition Standards of Hematopoietic Cellular Therapy Accreditation manual – pending is the 8th Edition of Standards scheduled for publication in May, 2021 and effective August, 2021.
  - FACT Quality Handbook, 2<sup>nd</sup> Edition
  - Explore the Education and Resources tab for presentations, webinars, recordings
- Fred Hutch Standard Practice Manual
  - The Fred Hutchinson Cancer Research Center has a Standard Practice Manual that gives detailed evidence-based information regarding all aspects of transplant patient management and care. It is written and maintained up-to-date by a dedicated transplant physician group. The manual can be purchased for a small fee. Contact Dr. Leona Holmberg at [lholmberg@fredhutch.org](mailto:lholmberg@fredhutch.org)

## Summary

This report describes the elements to be considered for developing a Pediatric Transplant and IEC Therapy Program for UV Children's Hospital. The University of Virginia already has a FACT Accredited Adult Transplant and IEC Program. The goal is for the new Pediatric program to be able to be combined with the adult program for purposes of FACT Accreditation as a Combined Cellular Therapy Program for Allogeneic, Autologous Transplantation and IEC Therapy.

Suggest working with the established adult cellular therapy program regarding potential of adding to or adapting already developed Quality Management Plan, Policies and Procedures. There is no need to have separate documents for the pediatric program, but review of the adult documents will be needed to see how changes may be needed to adapt to pediatric program needs. i.e., describing age related issues when appropriate. The pediatric team will need to have all policies and procedures available to all members of the pediatric team. The pediatric team will need to develop treatment protocols or standard treatment plans as well as electronic order sets for the patients they will be transplanting or treating with IEC therapy.

Recommendations in this report are based on FACT 7<sup>th</sup> Edition Standards and the experience of the FACT consultant.

## References:

1. Majhail NS, au L-W, Denzen EM, et al. Costs of Autologous and Allogeneic Hematopoietic Cell Transplantation in the United States: A Study Using a Large national Private Claims Database. *Bone Marrow Transplant* (2013) 48: (2): 295-300. DOI: 10.1038/bmt.2012.133
2. Stranges E, Russo CA, Friedman B. HCUP Statistical Brief #82. Agency for Healthcare Research and Quality, Rockville, NMD. Dec, 2009 Producers with the most rapidly increasing hospital costs, 2004-2007. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb82.pdf>
3. Khera N, Zeliadt SB, Lee SJ. Economics of hematopoietic cell transplantation *Blood* (2012) 120 (8): 1545-51 DOI: 10.1182/blood-2012-05-426783
4. Lin JK, Muffly LS, Spinner MA, et al. Cost Effectiveness of Chimeric Antigen Receptor T-Cell Therapy in Multiply Relapsed or Refractory Adult Large B-Cell Lymphoma. *Journal of Clinical Oncology* (2019) 37 (24): 2105-2119 DOI: 10.1200/JCO.18.02079
5. Whittington MD, McQueen RB, Ollendorf DA, et al. Long-term Survival and Cost-effectiveness Associated with Axicabtagene Ciloleucel vs Chemotherapy for Treatment of B-Cell Lymphoma. *JAMA Netw Open* (2019) 2 (2) e190035 DOI 10.1001/jamanetworkopen.2019.0035

### **Apheresis:**

The Pediatric Cellular Therapy program will utilize the FACT Accredited Apheresis Facility at University of Virginia that is part of the Adult Cellular Therapy Program.

For Apheresis Collection Facility collecting cellular therapy products from pediatric donors, physicians and collection staff shall have documented training and experience with pediatric donors (FACT Standard C3.4.2).

- Staff – the number of trained personnel shall be adequate for the number of procedures performed and shall include a minimum of one (1) designated trained individual with an identified trained backup to maintain sufficient coverage.

### **Processing Facility**

The Pediatric Cellular Therapy program will utilize the FACT Accredited Processing Facility at University of Virginia that is part of the Adult Cellular Therapy Program. There are adequate staff to handle the additional products collected from pediatric program.

### **Equipment Needs Pediatric Clinical Program**

1. **Computers** – every clinic room, nurses' station, every office, and patient room
2. **Refrigerator** – for transient storage of blood products for transfusion in clinic (if not already there).
3. **Bone marrow Harvest:** equipment needed for performance of the BM Harvest procedure

# **APPENDIX, DOCUMENT #7**

Department of Pediatrics

**MEMORANDUM OF UNDERSTANDING****Attachment A – Medical Center Commitments for Dr. Daniel Lee’s Offer Package**

Apheresis Capabilities	The Cytotherapy lab located on 8 West in the hospital will be used to process pediatric transplant patients.
	The Medical Center currently has nursing capabilities to cover pediatric patients. The Medical Center commits to maintaining appropriate staffing levels and hiring additional nurses should volume dictate the need.
	The Medical Center has adequate apheresis units to accommodate pediatric patients. If additional machines are required to accommodate volume, the Medical Center commits to purchasing this equipment.
HLA Lab	Access and use of the current Medical Center HLA lab will be granted.
Cytometry Lab	Access and use of the current Medical Center clinical flow cytometry lab will be granted.
Additional Staff	The Medical Center will provide a Nurse Practitioner (NP) and this position will be funded through the Cancer Center of Excellence (COE). The Medical Center is currently in the process of hiring a NP and this person will also assist as the transplant coordinator.
	The Medical Center will hire a Financial Coordinator at .25FTE with funding through the Cancer COE.
	The Medical Center will hire a Social Worker at .25FTE with funding through the Cancer COE.
Research Funding	The Health System (Larry Fitzgerald, Vice President of Business Development and Finance) has approved \$1,000,000 in research support to be funded through the Strategic Investment Pool. This will be paid at \$200,000 per year. The Department of Pediatrics will receive \$600,000 during Dr. Lee’s initial 3 year appointment. When Dr. Lee is reappointed, the Health System will provide two additional years of research support at \$200,000 per year.
Salary Support	The Medical Center Cancer COE will provide 50% of salary and fringe benefit support for Dr. Lee during his initial 3 year appointment. Through FY18 funding will be provided by the Cancer COE. Any funding required in FY19 will be provided through the normal MOU process. This 3 year commitment cannot exceed \$517,000 which represents the amount budgeted in the Cancer COE.

# **APPENDIX, DOCUMENT #8**

**Subject:** RE: Pedi SCTCT program requirements  
**Date:** Thursday, March 28, 2024 at 11:32:21 AM Eastern Daylight Time  
**From:** Misra, Madhusmita \*HS  
**To:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS  
**CC:** Engel, Michael E \*HS

Dr. Kent is asking about any possible patients. I think we should let him know of this patient with the caveats indicated below. I would definitely want to pull back the letter of medical necessity if Dr. Kent is willing to provide the necessary resources.

Madhu

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**From:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS <DWL4Q@uvahealth.org>  
**Sent:** Thursday, March 28, 2024 11:02 AM  
**To:** Misra, Madhusmita \*HS <ABP6BD@uvahealth.org>  
**Cc:** Engel, Michael E \*HS <MEE2MJ@uvahealth.org>  
**Subject:** Re: Pedi SCTCT program requirements

Hi Madhu,

On further consideration overnight I need more information before we can make a decision on this. In the past, Philip and I have agreed that a haploidentical transplant as our first few transplants would not be wise given the inherent higher risks involved. We have not run an unrelated donor search as this is generally done by the transplanting center (CHOP). I will ask our adult BMT colleagues to run a search for us to see what possible unrelated donors he has.

You should also know that a few days ago I provided a letter of medical necessity to his insurance arguing why he should be transplanted at CHOP because 1) they have a multidisciplinary program for the care of and transplant of kids with disorders with underlying immunodeficiencies and 2) a robust haplo transplant program – both things neither VCU or UVA has. It may be difficult logistically to walk that back.

Regardless, I will need to discuss with Philip once we get the MUD results. I will get restaging studies on the kid in about 5 weeks. If he is in a complete remission, then he would otherwise be ready for transplant. Of note, it takes a minimum of 6 weeks to get to haplo and minimum of 8 weeks to get a MUD from the time of the initial transplant referral. So, best case this will not happen for several months no matter where he is transplanted.

He is also only 12 yrs old so I seriously doubt the adult BMT group will agree to help with clinical effort.

Hope that helps  
Trey

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**From:** Misra, Madhusmita \*HS <ABP6BD@uvahealth.org>  
**Date:** Thursday, March 28, 2024 at 10:53 AM  
**To:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS <DWL4Q@uvahealth.org>  
**Cc:** Engel, Michael E \*HS <MEE2MJ@uvahealth.org>  
**Subject:** RE: Pedi SCTCT program requirements

Quick question.

For the patient that you mentioned who could be a possible transplant, how close are you to a decision

regarding this, and when would you know for sure? Could you give me the specifics?

Thanks,  
Madhu

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**From:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS <[DWL4Q@uvahealth.org](mailto:DWL4Q@uvahealth.org)>

**Sent:** Wednesday, March 27, 2024 10:40 PM

**To:** Misra, Madhusmita \*HS <[ABP6BD@uvahealth.org](mailto:ABP6BD@uvahealth.org)>

**Cc:** Engel, Michael E \*HS <[MEE2MJ@uvahealth.org](mailto:MEE2MJ@uvahealth.org)>

**Subject:** Pedi SCTCT program requirements

Hi Madhu,

Thank you again for taking a significant amount of time today to discuss the pediatric stem cell transplant & cell therapy program. I am hopeful you can be successful in securing real resources (see below) as we discussed. I realized tonight that the spreadsheet I mentioned outlining the requirements for FACT accreditation as well as the needs to start allo transplants was last updated in July and September, respectively. I need to update them. Once I do, I will send these along to you with the full evaluation by our FACT consultant, Dr. Jean Sanders. Please remember, that we already agreed to start allos last Fall, but this had to be put on hold when Sara (our PA) and Philip went out.

One caveat about our discussion and these resources – I have been told time and time again that we have the people in place and I can just use them. The problem is these folks and their direct supervisors are not told that some measure of time should be dedicated to transplant and so they are not given protected time away from their already full plates to dedicate to our program. When I approach these people directly, I am told there is no bandwidth to add transplant to their workloads. This results in no or minimal work done while the perception by leadership is that sufficient resources are in place but we just are not utilizing them. There appears to be a disconnect there. This is what I mean by needing real resources – not just words but tangible resources.

I'll have these documents to you as soon as I can.

Take care,  
Trey

DO NOT read, copy or disseminate this communication unless you are the intended addressee. This email communication contains confidential and/or privileged information intended only for the addressee. If you have received this communication in error, please notify me immediately via email or telephone that you have received the communication in error. Thank you for your cooperation.

# **APPENDIX, DOCUMENT #9**

**Subject:** Re: transplant progress.....

**Date:** Tuesday, June 13, 2023 at 11:44:16 AM Eastern Daylight Time

**From:** Engel, Michael E \*HS

**To:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS, Roehrs, Philip \*HS

Thanks so much, Trey!

The chatter has come from different directions, and not directly to me. So I too was surprised when I first heard it. The internal chatter seems to be coming from multiple sources, but I can't confirm precisely from where. People are reluctant to betray confidences. But I suspect folks in one or more supportive roles (nursing? PT/OT?) could be a source. More concerning to me is the prospect that this view is shared by some in health system leadership. Again, no proposal, and only hearsay, but I heard it mentioned from at least two sources that the topic of diverting resources to other programs has been mentioned. I don't think people want that outcome, but the fact that it has been mentioned is a concern to me. Other approaches, such as finding new leadership, are also not out of the question given what has happened with Peds ED. The way to protect this program is by moving ahead. I'm sharing what I have heard because it's important that you guys know.

With regard to the letter, we definitely need to have a signature from a representative of the health system. Billy is the obvious choice as ACMO for Children's Hospital. A unified message is essential.

I'll have a look at the letter today so we have it available for our meeting tomorrow.

Thanks.  
me

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**From:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS <DWL4Q@uvahealth.org>

**Date:** Thursday, June 8, 2023 at 3:09 PM

**To:** Engel, Michael E \*HS <MEE2MJ@uvahealth.org>, Roehrs, Philip \*HS <HFH6SZ@uvahealth.org>

**Subject:** Re: transplant progress.....

Hi Mike,

I would like to know who you are referring to when you say you've heard suggestions about pulling the plug and who is saying internally and externally "the program will never happen." I'd also like to know what your responses were. Were these people encouraged to bring their concerns to us? No one has ever expressed these sentiments to Philip or I. So, it would be helpful to know about them in order to address them.

Our group had previously drafted a letter to go out to the community sites. We put it on hold until we could ensure we had critical issues addressed, identified after Sam's transplant. Two weeks ago, now that we have a bit of breathing room after the last several patients (including RB) are taken care of, we decided it was time to send the letter. I just haven't yet as I was getting my big grant out this Monday. So, your email asking for the letter is timely. I have attached it here. While I appreciate the sentiment that we're all in this together, I'm not sure it needs everyone's signature though.

Trey

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**From:** Engel, Michael E \*HS <MEE2MJ@uvahealth.org>

**Date:** Wednesday, June 7, 2023 at 7:00 PM

**To:** Lee, Daniel W (Trey) (Pediatric Heme/Onc) \*HS <DWL4Q@uvahealth.org>, Roehrs, Philip \*HS <HFH6SZ@uvahealth.org>

**Subject:** transplant progress.....

Hi guys,

I've been reflecting on the email on Friday about changes to the ED leadership and organization and wanted to share with the two of you a concern that I have. I should start by saying that I have no back channel information about what drove this change, so these are just my thoughts, unfiltered.

Some could say this change is a long time in coming, but I also think the announcement was abrupt and the transition in leadership immediate. Bill Woods does not strike me as one who would have stepped down in this way, so I'm left to wonder if this was a forced transition. If so, to me it signals that in the wake of COVID, the health system leadership team seems willing to make abrupt changes when programs to which they have committed resources are underperforming. I don't think there is much appetite for reasons, only results. Obviously that brings me to stem cell transplant, which you both know is under considerable scrutiny. I am growing increasingly concerned that a similar fate could befall our transplant aspirations if we don't move forward deliberately, and in a visible way. I have heard it mentioned that some have suggested pulling the plug on pediatric transplant, and I've even heard from people in and out of UVA that, "this program will never happen". Frankly, it makes me angry to hear such words, and it intensifies my desire to prove these people wrong. Although I've not heard a proposal to divest from a commitment to pediatric transplant, chatter like this has a way of taking hold and becoming a self-fulfilling prophecy. We cannot let that happen. That result would be good for no one, certainly not the children we serve.

While you may have objections, I believe it's time for us to notify potential referring programs that we are accepting referrals. Would you please send to me the draft letter already in hand by Monday 6/12. After a chance to make edits, I wish to send this letter out by Friday, 6/16. As Chief, I will take responsibility for communicating our message to other programs. But I want each of us to sign the letter, and will ask Billy to sign as ACMO as well. We are in this together! I would also like to schedule presentations at CHKD and Roanoke as soon as possible, and additional programs as soon as possible after that.

I know you have reservations about safety issues, so these need to be spoken and addressed. But it's also important to acknowledge that our first allo transplant will not be perfect. There will be problems to solve, hurdles to overcome, and partnerships to forge. We will have to overcome them anyway, and by whatever means necessary. In announcing that we are open for business, safety-related issues that require resources will need to be addressed, whatever they are. All have openly stated that patient safety will be our guiding principle, and we will hold to this. I'm committed to doing whatever it takes to serve these patients and their families, and ultimately to becoming the place where everyone wants their children to receive care. We all have to lean in to achieve this goal.

I'd also like to say thanks to you both, and to Sara and Becky as well, for all you've done to get us to this point. I know it has been, and in some ways continues to be a Herculean effort. But a successful and vibrant transplant/cellular therapy program for children is essential to the evolution of our Division, our department and frankly, our institution. It's past time for us to move purposefully in this direction.

Best,  
Mike



# **APPENDIX, DOCUMENT #10**

[Medicine in Motion News \(https://news.med.virginia.edu\)](https://news.med.virginia.edu)

## **UVA Surgery Welcomes Ourania Preventza, MD, as New Chief of Cardiothoracic Surgery**

March 28, 2023 by [jta6n@virginia.edu](mailto:jta6n@virginia.edu) (<https://news.med.virginia.edu/author/jta6n@virginia.edu/>)



***Ourania Preventza, MD, MBA,  
FACS***

The Department of Surgery is pleased to announce the appointment of Ourania Preventza, MD, MBA, FACS, as the next chief of the Division of Cardiothoracic Surgery and co-director of the Heart and Vascular Service Line at UVA Health. She is currently a professor with tenure at Baylor College of Medicine. Dr. Preventza was selected after a very competitive national search. Feedback during the selection process emphasized her extensive experience in cardiac and aortic surgery, focus on collaboration across disciplines for building programs, and an uncompromising commitment to education and mentorship of others.

Dr. Preventza received her medical degree from the Medical School of Athens and completed her General Surgery Residency at Wayne State University and Cardiothoracic Surgery Residency at Albert Einstein College of Medicine. She also completed a Surgical Critical Care Fellowship at Mayo Clinic and earned an MBA from Brandeis University focused on health care policy.

Dr. Preventza is internationally known for her work in complex cardiac and aortic surgery, especially endovascular aortic techniques. She is currently President of the International Society of Endovascular Specialists and is a leader in several professional organizations including the American Association for Thoracic Surgery, Women in Thoracic Surgery, Society of Thoracic Surgery, and the Southern Thoracic Surgery Association. Dr. Preventza has contributed to more than 200 articles in peer-reviewed journals and serves on the Editorial Board of multiple cardiovascular journals including Associate Editor of Annals of Thoracic Surgery and Journal of Cardiac Surgery. Due to her commitment to excellence in mentorship and resident education, she recently was awarded the prestigious 2023 Socrates Award by the Thoracic Surgery Residents Association.

Dr. Preventza will be assuming the chief role on June 19, 2023. Please welcome her to the UVA family, the Department of Surgery, and the Division of Cardiothoracic Surgery.

# **APPENDIX, DOCUMENT #11**

## **Special Review of Thoracic Surgery-Independent/Integrated Residency Program**

### **Executive Summary of Special Review**

#### **Trigger**

A clinical learning environment in which trainees feel they have inadequate supervision, experience moral distress, and have been intimidated and harassed publicly.

#### **Special Review Team**

Jonathan Black, MD (Program Director, Plastic Surgery)

Robert DeVito, MD (Resident, Plastic Surgery)

Brad Kesser, MD (Interim DIO/Associate DIO)

#### **Findings and Action Items**

Trainees have been bullied and mistreated in educational conferences and have been put in situations of moral distress in the clinical learning environment, both in the operating room and in the inpatient setting. The Special Review team proposes the following suggestions:

1. A professional coach for the Division Chief, Dr. Preventza, to help her understand how her actions are perceived as bullying, intimidating, and harassing by the trainees. Failure to cease these unprofessional behaviors may result in the removal of trainees from clinical rotations and patient care (operative and inpatient) with Dr. Preventza.
2. A decision by the Chair whether to continue the culture of operative cases being staffed by two attending surgeons, potentially depriving the fellows of important learning opportunities.
3. Recognition by Dr. Preventza of the importance of our consulting teams and respecting the information and recommendations they provide.
4. Recognition by Dr. Preventza of the importance of the fellows and the information and recommendations they provide, along with their need for a graduated level of responsibility in patient care.

#### **Monitoring Plan**

The GMEC Annual Oversight Committee will continue to monitor the program's compliance and will review the 2024 ACGME Resident and Faculty surveys when the committee meets in the Spring. The Annual Oversight Committee will also request a trainee check-in and progress report to the GMEC 6 months after the execution of this report.

#### **Timeline**

Special Review initiated: March 2024

GMEC report:

Monitoring and/or follow-up: a trainee check-in and progress report from the program director to the GMEC 6 months after the execution of the report

Respectfully submitted,

Jon Black, MD  
Program Director, Plastic Surgery

Robert DeVito, MD  
Resident, Plastic Surgery

## **Full Report**

This Special Review of the Thoracic Surgery-Integrated program was triggered in March 2024 by reports of repeated instances of bullying, intimidation, and harassment by the Division Chief, Dr. Ourania Preventza, along with instances of moral distress experienced by the fellows.

Dr. Brad Kesser, Interim Associate Dean for Graduate Medical Education/Designated Institutional Official at the time, spoke with fellows and faculty who outlined specific instances of bullying and harassment, as well as episodes of moral distress the fellows have experienced since the arrival of the new Division Chief. Dr. Kesser notified the Department of Surgery Chair, Dr. Allan Tsung, that the GMEC would be conducting a Special Review of the Thoracic Surgery-Independent program based on these reports.

Jonathan Black, MD (Program Director, Plastic Surgery) and Rob DeVito, MD (Resident, Plastic Surgery) conducted the Special Review. Dr. Black spoke with the cardiothoracic attending surgeons, and Dr. DeVito spoke with the cardiac fellows, per protocol. This Special Review report represents a compilation of those conversations as written by Drs. Black and DeVito and discussed with Dr. Kesser.

The report addresses changes to the clinical learning environment and instances of bullying, harassment, and intimidation and cites specific instances where trainees have been in moral distress over patient care. Specific responses by the fellows are separated from faculty responses by topic.

### **Changes to the Clinical Learning Environment**

***CPR VI. The Learning and Working Environment Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:***

- ***Excellence in the safety and quality of care rendered to patients by fellows today***
- ***Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice***
- ***Excellence in professionalism***
- ***Appreciation for the privilege of providing care for patients***
- ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***

The trainees report significant changes to the clinical learning environment over the last 12 months. They correlate these changes with the arrival of the new Division Chief, Dr. Preventza. Proposed new divisional policy by the Division Chief includes a "co-surgeon" or "double-scrub" dogma at the attending level, which the trainees feel has and will continue to have a negative impact on their intra-operative learning. They report the Division Chief has regularly told trainees that they should "learn by observing" and "learn to crawl before they walk." The trainees feel that this policy has greatly reduced their learning opportunities and compromised their ability to learn procedural techniques in a safe environment with faculty supervision.

The trainees also feel that Dr. Preventza has taken away their autonomy on the floor and ICU. In the past, senior fellows would oversee the inpatient services with attending guidance and supervision. The senior residents and fellows would directly communicate with consulting teams and take ownership and leadership roles in caring for patients. However, Dr. Preventza

has regularly bypassed and excluded the trainees in decision-making, discussions with consulting services, and overall patient management. The Division Chief commonly requests the cell phone numbers of attendings from consulting services to make and enact patient care decisions and plans. The trainees report that this has taken away autonomy and learning opportunities and also projected a lack of trust or belief in their abilities to care for patients.

*Faculty response:* The Division Chief's initial interaction with the trainees was at a mentorship Grand Rounds in the summer of 2023 where she told the trainees at a luncheon that we have an unsafe cardiac surgery model at UVA. Cases should start with 2 attendings, and the critical portions of the case will be done that way (e.g., CP bypass). She stated she wouldn't want to be operated on by a resident/fellow to all the trainees. She told the faculty the same thing in August: "Baby (junior faculty) has to crawl before it walks."

The faculty concurs with the lack of fellow involvement and inappropriate fellow involvement in cases (see Moral Distress below). Faculty members perceive a fundamental cultural difference between the Division Chief's prior position at Texas Heart and UVA. Texas Heart has a 2 attending model with very little trainee participation vs. the UVA model of greater autonomy for the fellows with comprehensive fellow participation in patient care. The two attending model hasn't happened much at UVA due to faculty resistance. The Chief has made junior faculty stay with this model with no definite endpoint. The trainees are less interested in working with junior faculty due to this model.

The UVA model attracts outstanding fellows to UVA. The faculty feel recruitment efforts have been compromised by this culture change, and excellent candidates (including one internal candidate) are not attracted to UVA because of it.

### **Patient Safety, Quality Improvement, Supervision, and Accountability – Inadequate Supervision**

***CPR VI.A.2.a).(2) The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.***

*Fellow response:* Fellows feel the Division Chief has taken away their ability to manage patients in the ICU and on the floor due to micromanagement. More senior trainees express serious concern with the Division Chief's level of discomfort in the operating room, which commonly creates high stress scenarios. They report multiple instances where they feel the Division Chief was uncomfortable with the critical steps of procedures and required guidance or assistance from other attendings or senior trainees.

*Faculty response:* The faculty corroborated the fellows' concerns and relayed an incident where the Division Chief did not cover weekend calls. The Division Chief didn't see patients Dec 15-17 call weekend despite another faculty offering to cover call for her being sick. The fellow felt unsafe with a patient doing poorly. Dr. Preventza would not respond to either trainee or faculty who offered coverage. That faculty member came in on Sunday due to pleas from the trainee to help and ended up rounding on all the patients and staffing consults.

Overall, the faculty have concerns about safety of patient plans, the safety of doing the case independently, and weekend cases that are nonurgent.

### **Clinical Learning Environment – Alleged instances of bullying, harassment, intimidation**

***CPR VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.***

### **GMEC Policy 25: Learner Mistreatment (linked here)**

*Fellow response:* The trainees report repeated incidences of learner mistreatment, harassment, and unprofessional behavior involving the Division Chief and several different trainees.

1. An incident was described involving a Morbidity and Mortality (M&M) Conference presentation by a trainee. A trainee had prepared a presentation regarding a recent mortality from the cardiac surgery service involving an aortic pathology. From discussion with multiple trainees present for the incident, before the presenting trainee had finished the title slide they were interrupted by the Division Chief with a slew of statements and questions questioning the trainee's management of the patient. After the trainee restarted the presentation, they were interrupted again by the Division Chief with questions and antagonistic statements regarding patient management. A different faculty member then asked the Division Chief to allow the trainee to finish their presentation, at which time questions could then be asked. However, these interruptions continued. From discussions with multiple trainees, it appeared that the Division Chief had a goal to publicly bully and humiliate the trainee in front of their peers. After this incident, the Division Chief emailed an apology to the trainees. This incident was not spoken of in person at the conference or discussed individually with any trainees by the Division Chief.

The trainees report that their educational conference, which formerly was a protected space for learning and productive discussions regarding patient care, has become a hostile environment. They note that the presenting trainee has now been subject to what appears to be hostile beratement and public humiliation by the Division Chief.

2. An incident was described regarding intra-operative unprofessional behavior by the Division Chief. A trainee and the Division Chief were performing a procedure for a valve replacement in conjunction with the Cardiology (and Anesthesiology) service. The procedure proved more difficult than expected, and while the trainee was the operating surgeon, the Division Chief provided extremely negative feedback to the trainee in the public setting in front of the other services. After this incident, a member of one of the other teams filed a Be Safe event for the Chief's unprofessional behavior, which had a negative impact on patient care. Multiple trainees also described the Division Chief's multiple efforts to have a one-on-one meeting with the trainee to discuss this issue. The trainee in question, since they had not filed the complaint, was made extremely uncomfortable by these efforts, which included multiple unannounced visits to the trainee's shared office, where the Division Chief stated they were looking for the trainee in question to have a private one on one discussion with them. The trainee eventually

met with the Chair of the Department of Surgery. Overall, the trainee felt the attempts at a one-on-one conversation regarding the incident and multiple unannounced visits to their office felt like attempts at intimidation and retaliation by the Division Chief.

3. An incident was described by a trainee involving the Division Chief blaming them for a complication postoperatively. A patient underwent a sternal posterior table reconstruction. Preoperatively, the trainee attempted to discuss the plan for the procedure with the Division Chief multiple times, however they felt they were dismissed by the Division Chief. One month postoperatively, the patient presented to the hospital with a possible infectious complication. The Division Chief publicly blamed the trainee for the complication due to "poor closure" by the trainee and did not speak directly to the trainee. The Division Chief instead instructed a physician assistant and one of the more junior trainees to give this feedback to the trainee who had assisted in the case. The trainee felt uncomfortable with this situation due to a lack of ownership by the Division Chief, and they felt publicly humiliated that the Division Chief instructed a more junior trainee and non-physician to give them this feedback instead of having a discussion directly with them.

*Faculty response:* The faculty independently corroborated the fellows' description and characterization of the educational conference and the intimidating atmosphere created. They reported that on March 13, the Division Chief yelled at a trainee during M&M during the entire presentation, not allowing them to present the material.

The faculty also corroborated how the postoperative infection was handled. On March 27, a patient returned with a sternal infection. The Division Chief berated the trainee to another trainee during a washout procedure in the OR. She also berated and shamed the trainee to another faculty member and APP in a public hallway around other support staff. She told the faculty and APP to tell that trainee "not to do such a shitty job on closure."

The faculty discussed that the Director of the Advanced Cardiac Valve Center and the Cardiology and Cardiac Valve Fellowship Program Director, John Saxson, MD, reported unprofessional behavior of Dr. Preventza toward a trainee, Evan Rotar, MD (Resident, Thoracic Surgery-Integrated), for difficulty getting femoral access. They also stated that Interventional Cardiology Fellowship Program Director, Mike Ragosta, MD, reported unprofessional behavior of Dr. Preventza toward anesthesia residents during TAVR cases.

On April 26, the cardiac faculty formally submitted a list of concerns regarding inadequate supervision and learner mistreatment to the GME Office.

### **Well-Being - Instances of Moral Distress**

***VI.C. Well-Being: Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important***

***components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training***

Moral distress occurs when one knows the ethically correct action to take but feels powerless to take that action.

Fellow response: The fellows have been placed in challenging, morally distressing positions – positions where they feel patient care is not being best served due to decisions from the Division Chief.

1. An incident was described by multiple trainees involved in the evaluation of a patient exhibiting a post-op complication. After a patient who had undergone a cardiac procedure by the Division Chief was extubated in the ICU, the patient exhibited left-sided paralysis on physical exam. One of the senior trainees, who usually takes a very active role in management plans and decision-making with ICU patients, wanted to evaluate the patient for a possible stroke. They discussed this with the Division Chief, who overruled the suggestion. The Division Chief felt that these symptoms were more related to delirium and texted the fellow a specific request to not evaluate the patient for stroke and to specifically document other factors including delirium, alcohol use, and prior incidences of these symptoms after past procedures. The patient continued to exhibit signs and symptoms of left-sided paralysis. A trainee discussed this case on a weekend with the on-call cardiac surgeon. After that attending assessed the patient at the bedside, the decision was made to evaluate the patient for stroke. Imaging revealed a right-sided MCA stroke. The patient failed to recover postoperatively and expired in the hospital. The trainees involved in this patient's care were made to feel they were not providing optimal patient care. Specifically, the trainees note the importance of evaluating postoperative strokes in patients due to the need for an official diagnosis of a stroke to receive post-stroke care and to be a candidate for stroke rehabilitation protocols. Trainees report that this is not the only time they feel they have been overruled in evaluating the Division Chief's patients for potential complications.
2. An incident was described by a trainee involving the Division Chief ignoring the recommendations of a consulting service in the management of an ICU patient. The critically ill patient developed a potential requirement for insulin. The endocrinology service had been consulted in the care of this patient. A non-Thoracic Surgery trainee was managing the patient in the ICU at this time. The endocrinology service had specifically recommended not utilizing Glucommander in the care of this patient. However, the Division Chief ordered the non-Thoracic Surgery trainee to begin Glucommander on the patient. The Division Chief was aware that this was not in line with the recommendations of the consulting endocrinology service. Once Glucommander was begun on the patient, the endocrinology service notified the managing resident that this was against their recommendations and that they recommended for patient safety that Glucommander be stopped immediately. The Division Chief was again made aware of this and ordered the resident to continue Glucommander. The endocrinology service subsequently documented in the chart that the resident, who was named in the documentation, and the Division Chief were acting discordantly with their recommendations. The endocrinology service also filed a BeSafe regarding this incident. This trainee was not directly interviewed in the review process;

however from discussion with the trainees who were interviewed, that trainee reported finding this incident to be traumatic, distressing, and concerning regarding patient care.

3. An incident was described by a trainee involving the Division Chief attempting to have a different attending cover an emergent case due to special select trays of instruments not being available. On a heavy operative day, the cardiac surgery service received a consult for a type A aortic dissection, which requires emergent intervention. Multiple attendings were concurrently operating, and one attending was at home sick. Due to this circumstance and the Division Chief's expertise in aortic surgery, a decision was made to ask the Division Chief to assume care of the patient. When the plan for surgery was discussed, the Division Chief asked for special select instrument trays of theirs to be pulled. Unfortunately, these trays were not available. The Division Chief told the trainee staffing the consult that they could not take care of the patient without these instrument trays available. Due to this, the Division Chief asked the trainee to have a different attending, one who was at home sick, to instead assume care of the patient, and the Division Chief would take on an assisting role in the patient's care.

Faculty response: The faculty independently corroborated the trainees' concern about the patient with the postoperative stroke. On April 29, a patient had complete left-sided weakness after cardiac surgery. The Division Chief wouldn't evaluate the patient for stroke despite concern from trainee. Dr. Preventza asked the trainee to state in the record there wasn't a stroke which was in contradiction to neurology documentation. Patient died.

The faculty also reported that Dr. Preventza had placed fellows in uncomfortable positions in the operating room. Dr. Preventza's 1<sup>st</sup> heart surgery (CABG) was performed on a Saturday in October. Dr. Preventza couldn't drain the heart. She asked the fellow to mobilize the heart to view OM vessel, which is an advanced maneuver that typically isn't performed by trainees until the end of the fellowship. Another faculty member had to direct case.

## **Summary**

Points of tension within the program have emerged since the start of the new Division Chief, Dr. Preventza. The fellows feel that Dr. Preventza has created a hostile educational environment where they are frequently subjected to mistreatment, where they are concerned about retaliation, where they have been treated unprofessionally, and where they have been placed in situations causing moral distress. They report that they feel Dr. Preventza has a lack of interest in their education overall. They feel she has hindered their ability to learn intraoperatively by pushing for attendings double scrubbing cases. They also feel she has micromanaged patients and taken away their ability to manage patients in the ICU and on the floor. Faculty members in the Division have corroborated these sentiments.

## **Action Items**

The Special Review team proposes the following suggestions:

1. A professional coach for Dr. Preventza to help her understand how her actions are perceived as bullying, intimidating, and harassing by the trainees. Failure to cease these unprofessional behaviors may result in removal of trainees from clinical rotations and patient care with Dr. Preventza.
2. A decision by the Chair whether to continue the culture of operative cases being staffed by two attending surgeons, potentially depriving the fellows of important learning opportunities.
3. Recognition by Dr. Preventza of the importance of our consulting teams and respecting the information and recommendations they provide.
4. Recognition by Dr. Preventza of the importance of the fellows, the information and recommendations they provide, along with their need for a graduated level of responsibility in patient care.

## **Monitoring Plan**

The GME Annual Oversight Committee will continue to monitor the program's compliance and will review the 2024 ACGME Resident and Faculty surveys when the committee meets in the Spring. The Annual Oversight Committee will also request a trainee check-in and progress report from the program director to the GMEC 6 months after the execution of this report.

Respectfully submitted,

Jon Black, MD  
Program Director, Plastic Surgery

Robert DeVito, MD  
Resident, Plastic Surgery

# **APPENDIX, DOCUMENT #12**

Reid Adams/Wendy Horton

6/8/2022 – Met with Reid Adams and Peggy McNaul regarding TCV ICU Processes

12/7/2022 – met with Reid Adams, TCV ICU discussion

4/18/2023 – met with Reid Adams to discuss TCV leadership paradigm

12/12/2023 – met with Reid Adams; I met to discuss concerns of administration and my desire to leave the University due to this.

1/5/2024 – Rosner, Horton, Adams; I met to discuss quality and professionalism concerns and my desire to leave the University due to this. See email dated 12/18/2023

1/9/2024 – Adams, Horton; further discussion of above meeting

4/8/2024 – met with Allan Tsung regarding quality and professionalism concerns for Ourania Preventza

8/8/2024 – Review of quality slides for HSB with Hoke/Adams, discussion involved Kent's wishes to change my slides. See emails from Steve Long dated 11/25/2024. The changes in the slides would have me presenting only Vizient data for vascular surgery. As you may recall from our discussion, Vizient data is data for any surgeon that did a vascular procedure (including vascular, neurosurgery, general surgery, etc). The data that I had planned to provide was data just for our vascular surgeons (appropriate given the cases Kent had Chartis prepare were only our vascular surgeons). Vizient data would have backed up his claim that vascular surgery was in trouble if the data was not properly understood.

8/13/2024 – Review of Quality slides for HSB, discussion involved Kent's wishes to change my slides. See emails from Steve Long dated 11/25/2024

10/22/2024 – Surgical M&M of TAVR case

11/20/2024 - met with Heidi Ross for A3 for TAVR case; all quality data regarding this case lies within this A3, discussion around Ourania Preventza's hinderance of care for this patient as well as details of the case

11/1/2024 – met with Reid to discuss professionalism and quality concerns particularly around Ourania Preventza and Allan Tsung's poor leadership. I was told no decisions would be made until the W&C investigation was complete. Due to ongoing quality and professionalism concerns that were not being addressed, the Executive Committee of the Quality Subcommittee made the decision to proceed with reporting to the Credentials Committee. H&V service line leadership made aware.

11/21/2024 – M&M for de la Cruz case. Only a select group of people were invited to this rather than it being presented formally in our general M&M fashion. My notes regarding the de la Cruz investigation are contained in my notebook and were reported at surgical M&M to some degree and fully to Tracey Hoke (Chief Quality Officer) and Michael Ragosta (Credentials Committee Chair) prior to the M&M. Credentials Committee has formal documentation for this.

12/3/2024 – Tracey Hoke, discussion around quality and professionalism concerns for Ourania Preventza

1/8/2025 – Tracey Hoke, discussion around quality and professionalism concerns for Ourania Preventza and Kim de la Cruz.

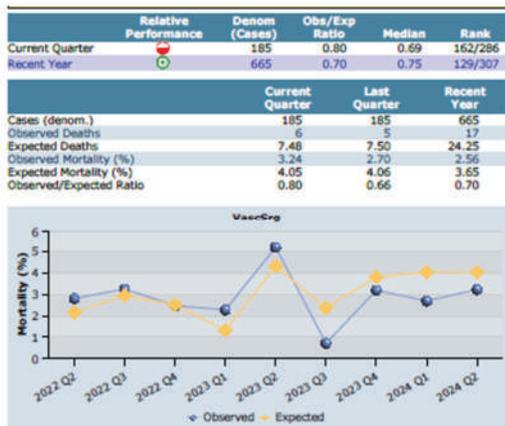
I also stated to Dr Tsung on one of our TCV ICU weekly meetings with the Executive Leadership group for the TCV ICU that I felt the search should be a failed search for cardiac chief. He declined saying that “Dr. Kent me (Tsung) that I had to hire someone.” This, of course, was prior to her hire. I do not know exactly which meeting date this was. This was during the time that I was interim medical director.

I also run quarterly H&V-wide M&M that involve the whole service line.

The Quality Committee meets monthly and there are minutes for all of these meetings.

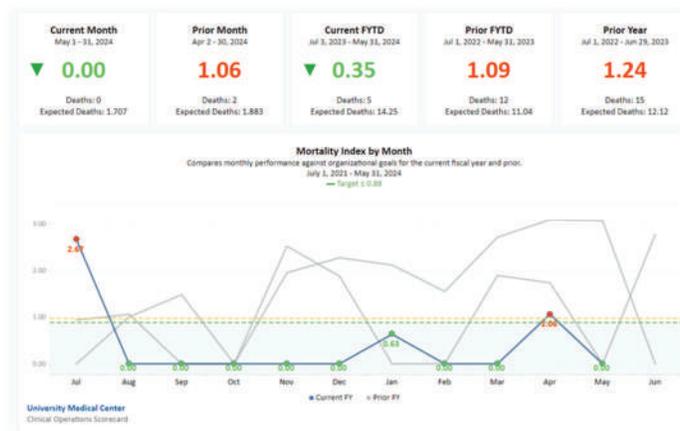
This is the slide illustrating the vascular data issue that I showed to W&C.

### Vizient



Includes all vascular surgeries, regardless of the specialty performing the operation

### UVA Dashboard



Includes only vascular surgery

This is the slide I showed to W&C illustrating increased vascular volumes in the face of excellent outcomes.

## Aortic Case Volume



- 43% case volume growth YOY (FY21-22) after establishment of Aortic Center
- Avg annual growth (last 5-ys): 6% per year
- Avg annual growth (last 3-ys): 12% per year



# **APPENDIX, DOCUMENT #13**



**Kim de la Cruz, MD**  
Physician  
Cardiothoracic Surgery

Consults    
Signed

Date of Service: 08/26/24 1216

### Cardiothoracic Surgery Consultation Note

Date of Consultation: 08/26/2024

Referring Physician: Behzad S. Farivar, MD (Vascular Surgery/Co-Director of Aortic Disease Program, UVA Health)

Reason for Consultation: Large chronically dissected extent II thoracoabdominal aortic aneurysm with contained rupture and large right-sided hemothorax

██████████ is a 79 year old African American male with hypertension, stage 3b chronic kidney disease (GFR 35), impaired glucose tolerance (hemoglobin A1c 5.9), advanced age, frailty, and dementia, who was emergently transferred from Southside Community Hospital in Farmville, VA to UVA Medical Center earlier this morning with complaint of "stomach pain." CT scan of the chest and abdomen with and without contrast was done there that showed a ruptured large thoracoabdominal aortic aneurysm with Stanford type B/DeBakey type IIIb aortic dissection associated with a large right-sided hemothorax. The patient was admitted to TCV PO for BP monitoring and control, where a right radial arterial line was placed by the critical care team, and anti-impulse therapy was instituted. All options were also in the process of being discussed with the patient and his family.

I was called by Dr. Farivar to emergently review the CT scans of ██████████ for his large chronically dissected extent II thoracoabdominal aortic aneurysm with contained rupture, and evaluate for repair options and potentially assist him with an emergent TEVAR. I have seen and examined ██████████ at the bedside. I have reviewed all available medical records and imaging studies.

The patient is lying comfortably on his ICU bed. On antihypertensive drips to maintain SBP between 90-120 mm Hg. Heart rate between 60-90 bpm. Currently not complaining of any pain. On high-flow O2 via nasal cannula at 42 liters/minute with FiO2 100%, saturating 100%.

CBC showed a WBC count of 16.06, hemoglobin of 10.9, hematocrit of 33.9, and a low platelet count of 49K. Patient received platelet transfusion. Repeat platelet count went up to 104K. Patient has hypofibrinogenemia, with a fibrinogen level of 60. Patient receiving cryoprecipitate. CMP showed a sodium of 137, chloride of 113, high potassium of 6.0 (repeat came back 4.8), low CO2 of 15, BUN of 31, high creatinine of 1.9, low GFR of 35, and high glucose level of 282. Hemoglobin A1c came back 5.9. AST is 34, ALT is 12, and alkaline phosphatase is 40.

I have personally reviewed the CT scans done in the OSH, and the repeat CTA chest/abdomen/pelvis done here at UVA Medical Center. I have made my own measurements of the various segments of the aorta as follows:

Aortic root = 3.749 cm,

Proximal ascending aorta = 4.066 x 4.020 cm,

Mid ascending aorta = 4.106 x 3.859 cm,

Transverse aortic arch = 3.582 cm,

Proximal descending aorta = 7.3 cm,

Mid descending aorta = 7.403 cm,

Distal descending aorta = 9.206 cm (this is where the contained rupture site is into the right pleural cavity from the true lumen; there are multiple fenestrations along the dissection flap where the true and false lumens communicate over the length of the entire thoracoabdominal aorta),

Abdominal aorta at the level of the celiac axis = 6.432 cm,

Abdominal aorta at the level of the SMA = 3.821 x 5.893 cm,

Abdominal aorta at the level the right and left renal arteries = 3.454 x 3.143 cm,

Infrarenal abdominal aorta = 4.239 x 3.161 cm,

Left common iliac artery = 1.619 cm, and

Right common iliac artery 1.156 cm.

There is chronic Stanford type B/DeBakey type IIIb aortic dissection from just distal to the left subclavian artery all the way down to the aortic bifurcation.  
There is rupture from the true lumen at the level of the distal descending aorta into the right chest cavity with associated large right-sided hemothorax.  
There are multiple fenestrations along the dissection flap and the true and false lumens communicate over the entire length of the thoracoabdominal aorta.  
The celiac axis, SMA, right renal artery, and right common iliac artery all arise from the true lumen.  
The left renal artery and left common iliac artery both arise from the false lumen.  
Both kidneys fill with contrast.  
There is chronic near total occlusion of the proximal portion of the celiac axis with reconstitution distally.

Based on the information stated above, although [REDACTED] meets criteria for emergent aortic repair, in my opinion he is at prohibitive risk (and therefore not a candidate for) for extent II open thoracoabdominal aortic aneurysm repair. Moreover, based on his aortic anatomy, in my opinion, he is also not a candidate for emergent thoracic endovascular aortic repair (TEVAR) - as the largest endovascular stent available is 46 mm, but the wall-to-wall aortic diameter at the distal landing zone just above the celiac axis in the distal descending aorta is much larger at 8.687 x 7.565 cm in diameter, while the wall-to-wall diameter of the false lumen at this level is 7.105 x 6.602 cm (even if the canalized portion of the false lumen is only 3.015 x 2.269 cm). In my opinion, it will not be possible to get adequate seal, enough to get control of the rupture site. There is also a lot of laminar thrombus within the lumens of the very large thoracoabdominal aortic aneurysm that embolization during the passing of wires and catheters up and down the aorta would likely result in embolization. And again, if the purpose of the emergent TEVAR is to tide the patient over to a definitive open repair, it comes back to the fact that the patient is not an open surgical candidate. One of the likely complications of the above mentioned interventions is renal failure requiring dialysis - to which the patient and his family are not agreeable to. Based on these, recommend continued conservative management consisting of BP and pain control, along with palliative care consultation for goals of care and DNAR-C in the event of progression of contained rupture to free rupture.

I have discussed the diagnosis, management plan, and my thought process regarding the case with the patient and his brother Sylvester, and the rest of his family present at the bedside. Risks (including, but not limited to, stroke, spinal ischemia, paraplegia/paralysis, heart attack, heart failure, respiratory failure that may or may not need prolonged mechanical ventilation and tracheostomy, renal failure that may or may not need dialysis, embolization, bleeding, infection, reoperation, bowel ischemia, liver failure, and death), benefits (including, but not limited to, unlikely chance that TEVAR will achieve seal of the leak, none), and alternatives (including, but not limited to, conservative management, open repair, endovascular repair, hybrid repair) were fully explained to, and understood by, the patient and his family. All questions were answered adequately and to their satisfaction.

I have reviewed the case and the CT scans with my Division Chief, Dr. Ourania Preventza, who concurs with the assessment and plan.

I have coordinated care with the patient's bedside ICU nurse, and Dr. Farivar.

Kim Insua de la Cruz, MD FACS  
Cardiothoracic and Aortic Surgeon  
Associate Professor of Surgery  
University of Virginia School of Medicine  
Co-Director, Aortic Disease Program  
UVA Health  
Office: (434) 924-9300  
Pager: 8392

Admission (Discharged) on 8/26/2024 *Note shared with patient*

## Care Timeline

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- 08/26 ● Admitted to 4 South 0829  
0829
- 08/26 ● Transferred out of 4 South 1323  
1323
- 08/26 ● ARTERY, ENDOVASCULAR OPEN REPAIR DESCENDING AORTA (TEVAR)(MAIN29/HYBRID LAB)  
1323
- 08/26 ● Transferred to 4 South 1906  
1906
- 09/11 ● Transferred out of 4 South 1723  
1723
- 09/25 ● Discharged 1303  
1303

# **APPENDIX, DOCUMENT #14**

**From:** Kramer, Christopher M \*HS (Cardiology)  
**Sent:** Tuesday, October 27, 2020 12:11 PM  
**To:** Dalkin, Alan \*HS <[ACD6V@hscmail.mcc.virginia.edu](mailto:ACD6V@hscmail.mcc.virginia.edu)>; Ferguson, Jef (James E) MD \*HS <[JEF2A@hscmail.mcc.virginia.edu](mailto:JEF2A@hscmail.mcc.virginia.edu)>; Hedrick, Traci \*HS <[TH8Q@hscmail.mcc.virginia.edu](mailto:TH8Q@hscmail.mcc.virginia.edu)>; Heim, Steven W \*HS <[SWH9E@hscmail.mcc.virginia.edu](mailto:SWH9E@hscmail.mcc.virginia.edu)>; Helenius, Ira \*HS <[IH4B@hscmail.mcc.virginia.edu](mailto:IH4B@hscmail.mcc.virginia.edu)>; Marzani, Gabrielle R (Attending/Admissions) \*HS <[GRM2A@hscmail.mcc.virginia.edu](mailto:GRM2A@hscmail.mcc.virginia.edu)>; Matsumoto, Alan \*HS <[AHM4D@hscmail.mcc.virginia.edu](mailto:AHM4D@hscmail.mcc.virginia.edu)>; Moskaluk, Christopher A (MD-PATH Surgical Path) <[CAM5P@hscmail.mcc.virginia.edu](mailto:CAM5P@hscmail.mcc.virginia.edu)>; Netland, Peter A \*HS <[PAN9C@hscmail.mcc.virginia.edu](mailto:PAN9C@hscmail.mcc.virginia.edu)>; Oberholzer, Brigitte \*HS <[BO7SE@hscmail.mcc.virginia.edu](mailto:BO7SE@hscmail.mcc.virginia.edu)>; O'Connor, Robert E \*HS <[REO4X@hscmail.mcc.virginia.edu](mailto:REO4X@hscmail.mcc.virginia.edu)>; Scheiman, James M \*HS <[JS5GG@hscmail.mcc.virginia.edu](mailto:JS5GG@hscmail.mcc.virginia.edu)>; Sheehan, Jason \*HS <[jps2f@hscmail.mcc.virginia.edu](mailto:jps2f@hscmail.mcc.virginia.edu)>; Solorzano, Genesis I \*HS <[GIS6D@hscmail.mcc.virginia.edu](mailto:GIS6D@hscmail.mcc.virginia.edu)>; Young, Jeff S \*HS <[JSY2B@hscmail.mcc.virginia.edu](mailto:JSY2B@hscmail.mcc.virginia.edu)>; Browne, James A \*HS <[JAB8HD@hscmail.mcc.virginia.edu](mailto:JAB8HD@hscmail.mcc.virginia.edu)>; Shaffrey, Mark E \*HS <[mes8c@hscmail.mcc.virginia.edu](mailto:mes8c@hscmail.mcc.virginia.edu)>; Williams, Michael E, MD, Heme/Onc \*HS <[MEW4P@hscmail.mcc.virginia.edu](mailto:MEW4P@hscmail.mcc.virginia.edu)>; Helgerson, Paul W. \*HS <[PWH3V@hscmail.mcc.virginia.edu](mailto:PWH3V@hscmail.mcc.virginia.edu)>; Petersen, William \*HS <[WCP3G@hscmail.mcc.virginia.edu](mailto:WCP3G@hscmail.mcc.virginia.edu)>; Enfield, Kyle \*HS <[KE4Z@hscmail.mcc.virginia.edu](mailto:KE4Z@hscmail.mcc.virginia.edu)>  
**Cc:** Kern, John A \*HS <[JAK3R@hscmail.mcc.virginia.edu](mailto:JAK3R@hscmail.mcc.virginia.edu)>  
**Subject:** Pre-procedural testing and service line leadership

All – We are sure you all are aware of the mass COVID exposure that occurred last week in the CCU that has resulted in multiple quarantine events that has in turn resulted in closure of the CCU, limiting of elective cath procedures, potentially delaying cardiac surgeries, and creating significant scheduling changes throughout the Heart and Vascular service line. All of this would have been preventable had we had pre-procedural COVID testing, which is presently offered in the vast majority of hospitals in the U.S. For some reason, our institution has delayed instituting this, leading us to our present situation. Apparently, medical center leadership is still not sold on this concept. It was discussed at the Chairs meeting yesterday, but we as Service Line leaders have yet to be consulted about it. We would like to bring this to the attention to medical center leadership, if other Service Line leaders are inclined to do so. Please let us know if you are willing to sign on to a letter in this regards and we will send it around.

Thanks,

Christopher Kramer MD and John Kern MD

Co-leads, Heart and Vascular Service Line

**"This email originated outside the organization. Do not click any links or attachments unless you have confirmed the legitimacy of the message."**

# **APPENDIX, DOCUMENT #15**

As the Public Directors, we represent both the physicians and nurse practitioners employed by UPG and the community that is served by these providers. We are your community board, and help to provide the connection President Ryan wants with the community. We have relationships in Charlottesville and with the regional geographies that UVA serves. We can help UVA understand and be responsive to the needs of these communities.

The Public Directors and UPG are also here to help advance the UVA Health system. As an organization, UPG can be the low cost strategic growth area of the health system.

Thirdly, UPG and the Public Directors are responsible for looking out for the well-being of the providers. If UPG can improve the satisfaction of the providers, UVA will be better able to recruit and retain a talented and diverse faculty. We all know, because we participated in the search for the executive vice-president, that the #1 issue facing the health system in the past several years has been a lack of trust.

UPG is fortunate to be led by a strong team, with Corey Feist as the CEO and Bobby Chhabra, the President. We believe that Corey and Bobby have done an excellent job representing the providers and fostering a positive collaboration with the chairs of the different departments. We also know that the community is extremely positive about the excellent care provided by the UVA providers.

There needs to be mission congruity across the Health System with a well articulated strategy that aligns across the hospital, the School of Medicine and UPG. To have that, there needs to be trust. Trust requires transparency, fully shared financial and operational information, the recognition of the value and interdependence of success across entities and missions, and willingness to compromise. We believe that UPG has been transparent and collaborative, and our financial information is audited annually.

Bobby and Corey have the trust of the providers. It will be important to include them in the process of planning and decision making moving forward. The chairs and the other providers want to feel their voices are heard, and they have crucial information and experience that should be taken into consideration as decisions are made. Although I understand that UVA's ranking is largely based on its research dollars, it is the practicing physicians who bring in most of the income, with the services they provide and from their grateful patients who donate to the University. There are specific issues that contribute to faculty dissatisfaction, such as salaries and burn out, but I think if the providers have a voice and a seat at the table, those specific issues can and will be addressed.

In summary, we need to create a culture of collaboration and trust, a culture where staff feel safe and comfortable communicating concerns to "higher ups," and confident that their views are valued and taken into account. Transparency and inclusion can and will do a lot to change the culture. We hope you see UPG as a positive resource, and that this is the first of many conversations. We look forward to hearing your ideas and plans to build a collaborative, positive culture, and to working with you to accomplish this goal.

# **APPENDIX, DOCUMENT #16**

## Questions for the meeting on June 30, 2021

1. We would like to better understand the purpose and intent of the AAF? If its purpose is to reimburse the University for “agreed” costs of space and services per the Affiliation Agreement, then we would like more clarity surrounding those costs, i.e. itemization of those costs and services, so that we can better understand what we are buying and at what price.
2. Relatedly, how does the SOM use the funds and what amounts are needed from UPG to satisfy those uses? While we have not pressed for greater transparency in years past, there is precedent for clearer sharing of cost allocation. In fact, per Exhibit V of the Agreement itself, we were provided with schedules showing the allocation of general and administrative costs based on 1979-1980 cost data. With increased cost transparency, could UPG and the SOM jointly identify savings opportunities that could potentially benefit us both?
3. How was the 8% determined in 1991, and how was the determination made to reduce it to 7.5%? Are those reasons and assumptions still valid today? Is the percent of gross professional fee collections still the appropriate measure for payment, or is there a more modern approach we could consider that would better align the operational and financial interests of UPG, SOM and the Medical Center (e.g. a more simplified funds flow methodology)? As an example, if the AAF covers office lease expense, then given the current focus on remote work, could this be an ideal time to engage in a conversation to reduce the administrative footprint of the clinical departments?
4. Dr. Kent said that \$25-27M of the approximately \$35M UPG transfers to the SOM is a “pass through” for the cost of the space the departments use. For the FY21 budget, UPG expected to pay \$26.5M in AAF with the remaining \$6.6M of academic transfers to cover the Department specific costs for research and teaching. If these numbers are accurate, then the Dean is actually not keeping any of the AAF for SOM uses. How is it possible that the space costs this much? How was that number determined? Should we engage an independent third party valuator to appraise the space?

We are committed to working with you to create a financial structure that works to the benefit of the entire Health System. We believe it is important to better understand how the different parts of the system operate and interface currently so we can work toward the best alignment and functioning of the system as a whole.

# **APPENDIX, DOCUMENT #17**

DRAFT

We are here today as concerned fiduciaries of UVA Health. We serve on UVA Health boards, we are UVA Health patients, we are dedicated members of the Charlottesville community, and we all want to see UVA Health thrive. All of us have given our time to help UVA Health meet the needs of UVA clinicians and nurses as well as the patients in our community and region.

And we are here today because we have deep concerns about UVA Health leadership. Many of us participated in the search process to identify the priorities for the EVP position. They were: 1) Build trust. 2) Create alignment through collaboration across the health system. 3) Develop a strategic plan. To accomplish all this, it was emphasized that physician leaders would need to have a significant voice in the planning process.

Each of us has examples of how these priorities are not being met. We understand that many of these have been shared with you. I have also had numerous conversations with UVA physicians and nurses. They have described the very negative and frequent bullying experiences they have had with Dr. Kent and his administrative leadership team. He has actively discouraged open communication between the chairs by forbidding them from meeting as a group without his presence. He also controls broader communications of his direct reports by insisting that his communications team or he himself review messages before they are widely distributed to their own team members. Townhalls are highly produced and speakers are given scripts. He accomplishes this by making clear to anyone with an appointed position – whether a department chair or an administrative leader – that their jobs will be jeopardized if there is any dissent or noncompliance with his wishes. No debates or discussions. This is definition of tyranny.

Dr. Kent has spent millions on consultants (\$12 million, we understand), as well as hired ~~20~~ ~10 new senior administrators while pushing aside nearly every prior physician leader, dismissing the valuable insights and contributions of these dedicated professionals who have spent decades devoting themselves to UVA Health. Only one of his new leadership hires is a physician. Wendy Horton, the CEO of the Medical Center was hired as the COO without a search on an HR exemption ~~without a search~~ and was then promoted to CEO without meaningful

discussion. This event is, something that (as far as we know) had never happened previously at UVA Health. At this level of University leadership, this action belies Dr. Kent's disregard for UVA's own recruiting standards that stands in contradistinction to UVA's stated commitment to fair and equitable hiring practices.

We understand that the pandemic has had a significant impact on operations and the financial results of the entire system. No doubt there were, and continue to be, tough choices to be made. However, instead of looking out for the very people UVA Health had to count on to deliver care in an unprecedented environment, one of Dr. Kent's first actions was to layoff and furlough employees and cut their salaries. This decision was Dr. Kent's and Dr. Kent's alone. Unlike VCU where no layoffs or furloughs ~~or pay cuts~~ occurred or Novant who managed employee bonuses, Dr. Kent's actions left our people feeling devalued and unappreciated. Nothing has been done subsequently to change that widespread feeling. As a result, many have left or are in the process of leaving. There are currently 300 unfilled nursing positions and over 200 travel nurses. Including salary, signing bonuses, housing allowances and incentives, the cost of these travel nurses is more than double the cost of our staff nurses. Another failure of leadership was to pay our nurses a \$1,500 appreciation bonus this summer. There are many care providers at UVA Health that are not nurses, and they felt slighted. This short-sightedness is indicative of the expedient approach of the current leadership team. With a small degree of collaboration and planning, that money could have been used much more effectively and received a much better return for UVA Health. Many of our most experienced physicians have left or stepped down as chairs, only to be replaced by less experienced physicians who have minimal experience working at UVA Health or in senior leadership roles. In addition, several administrative leaders at UPG have recently resigned due to the frustration and difficulty of working with UVA Health leadership.

We are concerned about the declining reputation of UVA Health. We are no longer the #1 hospital in the state and not one department was ranked in the top 50 in the country—the first time in over 30 years this has occurred. The patient satisfaction scores have declined significantly as have quality outcomes. This is demoralizing for physicians and providers. As one physician said to me, “We are not here to be average, and UVA is losing its academic prestige.” Hundreds of patients are leaving our ER each week without being seen due to long wait times

and staffing issues. In the month of August, 834 people who came to the ED left without being seen. This raises patient safety issues, and damages UVA's reputation in Central Virginia. We are unable to open over 100 beds in the hospital, we turn away transfers from community hospitals daily that need our help, and we are cancelling elective revenue generating cases due to staffing issues. While these are complex issues, Dr. Kent's poor leadership decisions bear responsibility. There is a failure of leadership to problem solve and prioritize patients.

One of Dr. Kent's largest failures of duty is there is still no strategic plan for UVA Health. After 20 months, we find ourselves waiting for input from the new chief strategic planning officer who has no experience in academic health care, from groups within the health system and from the community. If the purchase of the three northern Virginia hospitals is any indication of what is to come for UVA Health, we are concerned. Dr. Kent described a vague plan which seemed comprised of "...running the hospitals better". Now we witness the accumulating hidden costs of this acquisition. Further, weeks after the purchase was complete, the doctors at these hospitals knew nothing of any plan, "We're walking in the dark." Several resigned in the first few weeks, and we understand that more are planning their exits. At the least, there could have been a plan of engagement in place between the Novant physicians and the UVA physicians.

Senior faculty are aware of Dr. Kent's discriminatory hiring practices and his termination of team members without cause in violation of HR policies. UPG recently lost its top candidate for the CAO position, an African American woman who was working in the Health System, when she chose to go elsewhere because of Dr. Kent's lack of support for Under Represented Minorities. Faculty are also aware of several HR complaints against Dr. Kent for discrimination and bullying of team members. Present and former senior members of UVA HR privately confide that they have seen obvious HR policy violations directed by Dr. Kent but that were bullied into executing them. At least two of these HR professionals resigned to avoid their own personal liability.

We have repeatedly attempted to work with Dr. Kent. As his suggestion, I planned a meeting with him, J. J. Davis and all the public directors. The agreed upon topic was the financial structure of the health system with the purpose of improving the alignment between the medical center, the school of medicine and

UPG. I prepared questions ahead of time and sent them to all involved. At the opening of the meeting, Dr. Kent asked where we wanted to start, but when I suggested we start with the first question, he admitted he did not have the questions. Clearly, he had not taken the time to look at them, let alone come up with answers to them. It was almost two months later, the week before this meeting, that the public directors received answers to those questions. Dr. Kent does not listen, and he seemingly does not care about input from others. Instead, he tries to pacify us with platitudes and rhetoric.

We have lost confidence in Dr. Kent's ability to lead UVA Health. None of the three priorities identified for the EVP position have been met or are in any way aligned with Dr. Kent's actions in the past 20 months. We have worked hard to collaborate with him, but have been met with the same behaviors that led to the vote of no confidence he received at Ohio State (or, the same behaviors that got him into trouble at the previous institutions that employed him.) *We are here to express our deepest concerns over his leadership and over the future of UVA Health with Dr. Kent at the helm.\** We do not have faith that Dr. Kent has the ability or the character to successfully implement the three priorities he was hired to carry out. We understand that we have no authority over him, and we have certainly learned that we have no influence. We are seeking your help.

What plans do you have to address this serious situation?

# **APPENDIX, DOCUMENT #18**

Dear Public Directors,

I want to tell you about my conversation with J.J. Davis and Craig Kent yesterday. I conveyed our concern about the UPG financial situation, and specifically that an agreed upon strategic goal (between George and Craig) to institute Funds Flow, has never happened. I said that the Public Directors are looking at ways to cut costs, and some of these will have a financial impact on the departments and the medical center. I let them know the Public Directors are unlikely to approve another deficit budget. I also went into our concern about the cost of losing so many nurses and hiring traveling nurses, not being able to staff 76 beds, and more, tying that to the bigger financial picture. I brought up the cost of the consultants, new administrative positions, the Monticello Surgery Center and the Novant hospitals and asked where the money came from to pay for them. Craig explained that the Novant hospitals were all “internally financed by the JOC” and the debt will be paid for with the cash generated. I didn’t want to be too aggressive so I didn’t ask this, but I think the next question has to be, “What happens if they don’t generate enough cash to pay the debt?” Who pays then?

Basically, I think Craig was very angry about what I said. He said that physician turnover at UVA is low compared to the national average, 3.9-4.1% versus 6% nationally. He was especially irritated that I mentioned the number of APPs that have left because, at my suggestion, he put together a group to look at their role. This is true, though he said they’ve met 4 times, and I’m not sure that’s accurate. I’ve reached out to Becky Compton, she’s the UPG APP representative, to find out more about these meetings. The last I heard from her a couple of weeks ago, she was very frustrated- lots of talk without goals and direction. Generally, Craig spoke and J. J. listened. I think she understood that there’s been a lot of talk and consultants, focus groups etc., but not much has changed. Toward the end of the meeting, when I still had not gotten the data about the health system reserves, Craig suggested monthly meetings with the Public Directors, and the plan is that J. J. will also attend. I said that I would want those meetings to have a focus, and the first one should be on the financial situation. I didn’t get into this with them, but I would want us to have specific goals and even a time table as there’s been a lot of talk with little action in my experience.

Melanie will be reaching out to you about times to meet, first with Susan Rumsey to bring you all up to date on the UPG financials, and then for the meeting with Craig and J. J. Please let me know if you have any questions or feedback. I appreciate your input.

Best,  
Julie

# **APPENDIX, DOCUMENT #19**

Thank you for taking the time to meet with us today. Since I know you received the letter I sent you both a few weeks ago, I won't spend time going over the same ground. I will just spend a few minutes to emphasize a couple of points and provide some context.

I am not here to defend the status quo or complain about change. But, I am concerned about the current environment under Dr. Kent's leadership that has resulted in more and more talented physicians and nurses leaving and a decline in the quality and reputation of the healthcare provided at UVA.

I became the chair of UPG in January 2021. As the chair, I met weekly with UPG leadership and at least monthly with Dr. Kent. I heard from UPG constituents, physicians and APPs of their increasing frustration and dissatisfaction with UVA Health leadership. I began to experience a similar sense of frustration and futility in my meetings with Dr. Kent. We discussed issues and possible solutions, but nothing changed. I offered to discuss the restructuring of UPG because Dr. Kent repeatedly emphasized the importance of being "one" health system. We offered to help with a physician strategy for the northern Virginia hospitals because we knew the lack of such a strategy was largely responsible for the failure of those hospitals to thrive. Then, in May we were informed by our CFO that our budget for the next year would have a 13M deficit. As directors with fiduciary responsibility, we were understandably concerned. There were many discussions about how best to address the situation. At one point, Dr. Kent said that we could not discuss lowering the Dean's tax. I was reminded of Dr. Kent telling the chairs when he first arrived that they could not meet without him present. Drew and I talked, and decided we would in fact talk about whatever we considered relevant, that while Dr. Kent is the EVP, he is not in control of our conversations.

It was after the June 30<sup>th</sup> meeting with Dr. Kent, JJ and the public directors, a meeting Dr. Kent suggested, that I realized that nothing I was trying to do to problem solve with Dr. Kent was getting anywhere. I'm 71 years old and time is important to me. While I have been very committed to supporting UVA Health, I know when my efforts aren't making any difference.

I decided that I needed to reach out beyond UPG to learn for myself how the physicians and nurses on the front lines were feeling and how the health system was functioning. I have already given you the summaries of many of my conversations with professionals at UVA Health as well as emails I received from them. I gave you those and asked to meet so I could share what I had learned. Sadly, most of the physicians, APPs and staff did not feel it was safe to speak up. That's why I'm here.

In the Cavalier Daily this week, Dr. Kent was interviewed about the purchase of the Culpeper, Prince William and Haymarket hospitals. I quote, "A second area of improvement is offering greater access to care by growing the physician workforce. Kent points out that there are simply not enough primary care physicians to meet the healthcare demand." I read this shortly after I received a letter of resignation from a UVA primary care physician that was forwarded to me. This is what she wrote: "Here at UVA, our clinics are not adequately staffed. We are not supported in helping our patients live better and longer. We have a staffing crisis precipitated by multiple faculty resignations. We have lost our minority faculty. Our conversations with the health system frame us as a financial liability and, at best, a source of referrals for more lucrative encounters such as ER visits, specialist visits and hospitalizations. It is possible that in the future, I will return. An institutional commitment to primary care, that is palpable to those providing care on the front lines, would hasten my return."

This is the problem we keep facing. Dr. Kent says all the right things, but they don't translate into the right actions. At the same time that Dr. Kent emphasizes the importance of primary care, he is not supporting those very doctors here in Charlottesville. This is the story in many, many situations. I was hopeful at the very beginning. What Dr. Kent advocated sounded promising, but it's not what has happened. I am very sad about the state of UVA Health, however, I know that other than bringing these issues and the voices of the providers to your attention, I can't fix this, only you can.

# **APPENDIX, DOCUMENT #20**

## Lynn Swanson

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**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <AMT6B@uvahealth.org>  
**Sent:** Friday, January 10, 2025 11:35 AM  
**To:** Lynn Swanson  
**Subject:** FW: UVA Cath Lab: Overdue Cordis orders

---

**From:** Shifflett, Emily \*HS <[EB4G@uvahealth.org](mailto:EB4G@uvahealth.org)>  
**Sent:** Wednesday, November 13, 2024 2:45 PM  
**To:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>  
**Subject:** Fw: UVA Cath Lab: Overdue Cordis orders [External\_Email]

Emily Shifflett ARRT (R)(CV)

Supv Imaging Tech 2

University of Virginia

Cardiac Cath Lab

[Eb4g@uvahealth.org](mailto:Eb4g@uvahealth.org)

Cell: [434-465-9655](tel:434-465-9655)

PIC: 6993

---

**From:** Daniel, Glenda <[glenda.daniel@cordis.com](mailto:glenda.daniel@cordis.com)>  
**Sent:** Tuesday, August 13, 2024 12:30:15 PM  
**To:** Shifflett, Emily \*HS <[EB4G@uvahealth.org](mailto:EB4G@uvahealth.org)>  
**Subject:** Re: UVA Cath Lab: Overdue Cordis orders [External\_Email]

Hi Emily,

UVA has been on credit hold for 2 weeks. They released a few orders as a courtesy but are waiting for additional payments. You may want to let accounts payable know that you have products you need. It is my understanding that

we have had numerous emails and calls and were told that they have what they need from Cordis but don't seem to be making much progress towards a resolution.

Thanks,  
Glenda

Get [Outlook for iOS](#)

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**From:** Shifflett, Emily \*HS <[EB4G@uvahealth.org](mailto:EB4G@uvahealth.org)>  
**Sent:** Tuesday, August 13, 2024 11:07:21 AM  
**To:** Daniel, Glenda <[glenda.daniel@cordis.com](mailto:glenda.daniel@cordis.com)>  
**Subject:** FW: UVA Cath Lab: Overdue Cordis orders [External\_Email]

Hi Glenda can you get us info on these overdue orders? Thank you!

Emily Shifflett ARRT (R)(CV)

Supv Imaging Tech 2

University of Virginia

Cardiac Cath Lab

[Eb4g@uvahealth.org](mailto:Eb4g@uvahealth.org)

Cell: 434-465-9655

PIC: 6993

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**From:** O'Connor, Sam <[Sam.O'Connor@owens-minor.com](mailto:Sam.O'Connor@owens-minor.com)>  
**Sent:** Tuesday, August 13, 2024 9:45 AM  
**To:** CORDIS CUSTOMER SUPPORT <[GMB-CORDIS-CUSTOMER-SUPPORT@cordis.com](mailto:GMB-CORDIS-CUSTOMER-SUPPORT@cordis.com)>  
**Cc:** Shifflett, Emily \*HS <[EB4G@uvahealth.org](mailto:EB4G@uvahealth.org)>  
**Subject:** UVA Cath Lab: Overdue Cordis orders [External\_Email]

**EXTERNAL EMAIL:** This message was sent from outside of UVA Health. Please use caution when replying, clicking links or opening attachments.

Good morning,

I have attached a file of all the Cordis Overdue Orders that we have over here at University of Virginia Cath Lab. I was wondering if you can provide me updates on the PO's, so I can update them on my side and let the clinical staff know. I figured this would be easier for both myself and customer service, so I'm not overloading them with PO's.

Thanks,

Sam



**Sam O'Connor** | Supply Chain Solutions Analyst  
Owens & Minor

Cell phone #: **804-543-0316**

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## Lynn Swanson

---

**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <AMT6B@uvahealth.org>  
**Sent:** Friday, January 10, 2025 11:36 AM  
**To:** Lynn Swanson  
**Subject:** FW: Philips UVA Statement of Account/Hold

---

**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine)  
**Sent:** Tuesday, November 19, 2024 3:01 PM  
**To:** Hoke, Tracey R \*HS <[TRH9K@uvahealth.org](mailto:TRH9K@uvahealth.org)>  
**Subject:** FW: Philips UVA Statement of Account/Hold [External\_Email]

---

**From:** Monfredi, Oliver J \*HS <[OJM9W@uvahealth.org](mailto:OJM9W@uvahealth.org)>  
**Sent:** Tuesday, November 19, 2024 10:37 AM  
**To:** Roach, Holly L \*HS <[HLR5A@uvahealth.org](mailto:HLR5A@uvahealth.org)>; Mason, Pamela \*HS <[PKM5F@uvahealth.org](mailto:PKM5F@uvahealth.org)>  
**Cc:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Silva, Demaris A \*HS <[DAS3AE@uvahealth.org](mailto:DAS3AE@uvahealth.org)>; Choffel, James \*HS <[JWC2Q@uvahealth.org](mailto:JWC2Q@uvahealth.org)>; Canty, James W \*HS <[JWC4R@uvahealth.org](mailto:JWC4R@uvahealth.org)>  
**Subject:** Re: Philips UVA Statement of Account/Hold [External\_Email]

---

Thanks Holly.

This is having real effects at the patient safety level.

Yesterday I had to extract a Medtronic CRTD, 9 yrs old, in an 88 yo male. I was told before the case that we did not have an 11Fr tightrail.

The 11 Fr tightrail is a go to tool for this case. The alternative is a larger tightrail which exposes the patient to excessive risk - the greater the mismatch between the size of the tool and the device component what we are trying to get out, the greater the risk of damage to critical structures including the SVC and the tricuspid valve.

We should not be asked or expected to do these procedures without the full rage of tools to be able to achieve excellent results safely.



Dr Oliver Monfredi  
MBChB PhD FRCP (London) FHRS

Associate Professor of Medicine

Medical Director, Complex Lead  
Management and Extraction  
Center of Excellence

e: [oliver.monfredi@uvahealth.org](mailto:oliver.monfredi@uvahealth.org)

p: 434-924-2031

---

**From:** Roach, Holly L \*HS <[HLR5A@uvahealth.org](mailto:HLR5A@uvahealth.org)>

**Sent:** Tuesday, November 19, 2024 10:32 AM

**To:** Mason, Pamela \*HS <[PKM5F@uvahealth.org](mailto:PKM5F@uvahealth.org)>; Monfredi, Oliver J \*HS <[OJM9W@uvahealth.org](mailto:OJM9W@uvahealth.org)>

**Cc:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Silva, Demaris A \*HS

<[DAS3AE@uvahealth.org](mailto:DAS3AE@uvahealth.org)>; Choffel, James \*HS <[JWC2Q@uvahealth.org](mailto:JWC2Q@uvahealth.org)>; Canty, James W \*HS <[JWC4R@uvahealth.org](mailto:JWC4R@uvahealth.org)>

**Subject:** FW: Philips UVA Statement of Account/Hold [External\_Email]

Hi all,

I added the Philips credit hold back onto the hospital's MESS board for the leadership huddle today. Supply Chain / AP updated they met last night to discuss moving forward with increasing the credit limit so it's not a continual issue. I reiterated that I need a timeline and resolution asap as our orders are being held and we have inpatients reliant on these supplies. I just wanted to keep you all in the loop. I haven't received an answer on this specific invoice, but will follow-up again. This is one of the most frustrating issues as there is little communication coming back to me.

---

**From:** Garrison, Misty Lynn \*HS <[MLM9ZA@uvahealth.org](mailto:MLM9ZA@uvahealth.org)>

**Sent:** Monday, November 18, 2024 3:43 PM

**To:** Roach, Holly L \*HS <[HLR5A@uvahealth.org](mailto:HLR5A@uvahealth.org)>; Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>; R Healthsystem\_Ap <[RHEALTHAP@uvahealth.org](mailto:RHEALTHAP@uvahealth.org)>; R UVAHS Cash Operations <[RUVAHSCASHIERING@uvahealth.org](mailto:RUVAHSCASHIERING@uvahealth.org)>

**Cc:** Forsman, Karen L \*HS <[KSL@uvahealth.org](mailto:KSL@uvahealth.org)>; Marquardt, Michael R \*HS <[MRRM2FP@uvahealth.org](mailto:MRRM2FP@uvahealth.org)>; Momper, Adam \*HS <[AM6JK@uvahealth.org](mailto:AM6JK@uvahealth.org)>; Hawkins, Shelley A \*HS <[SAH3VC@uvahealth.org](mailto:SAH3VC@uvahealth.org)>; Cloonan, Christopher A \*HS

<[CAC7SC@uvahealth.org](mailto:CAC7SC@uvahealth.org)>; Kaur, Sami \*HS <[GJA5JC@uvahealth.org](mailto:GJA5JC@uvahealth.org)>; Silva, Demaris A \*HS <[DAS3AE@uvahealth.org](mailto:DAS3AE@uvahealth.org)>

**Subject:** RE: UVA Statement of Account/Hold [External\_Email]

Thank you, it would appear that a credit review is recommended. Can you kindly provide the next steps to increase our credit limit?

Thanks,

*Misty Garrison*

*Director, Procurement Operations*

434.320.6757

---

**From:** Roach, Holly L \*HS <[HLR5A@uvahealth.org](mailto:HLR5A@uvahealth.org)>

**Sent:** Monday, November 18, 2024 3:36 PM

**To:** Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>; R Healthsystem\_Ap <[RHEALTHAP@uvahealth.org](mailto:RHEALTHAP@uvahealth.org)>; R UVAHS Cash Operations <[RUVAHSCASHIERING@uvahealth.org](mailto:RUVAHSCASHIERING@uvahealth.org)>

**Cc:** Forsman, Karen L \*HS <[KSL@uvahealth.org](mailto:KSL@uvahealth.org)>; Marquardt, Michael R \*HS <[MRM2FP@uvahealth.org](mailto:MRM2FP@uvahealth.org)>; Momper, Adam \*HS <[AM6JK@uvahealth.org](mailto:AM6JK@uvahealth.org)>; Hawkins, Shelley A \*HS <[SAH3VC@uvahealth.org](mailto:SAH3VC@uvahealth.org)>; Garrison, Misty Lynn \*HS <[MLM9ZA@uvahealth.org](mailto:MLM9ZA@uvahealth.org)>; Cloonan, Christopher A \*HS <[CAC7SC@uvahealth.org](mailto:CAC7SC@uvahealth.org)>; Kaur, Sami \*HS <[GJA5JC@uvahealth.org](mailto:GJA5JC@uvahealth.org)>; Silva, Demaris A \*HS <[DAS3AE@uvahealth.org](mailto:DAS3AE@uvahealth.org)>

**Subject:** FW: UVA Statement of Account/Hold [External\_Email]

Hi Josie,

Can you provide an update on invoice #9026512468? Was it one of the invoices overnighted for payment today? Philips is still holding orders. We have more inpatient lead extractions pending this week that are dependent on these supplies. When do we expect resolution so this isn't a weekly battle? Thanks!

---

**From:** Orebaugh, Courtney <[courtney.orebaugh@philips.com](mailto:courtney.orebaugh@philips.com)>

**Sent:** Monday, November 18, 2024 3:20 PM

**To:** Roach, Holly L \*HS <[HLR5A@uvahealth.org](mailto:HLR5A@uvahealth.org)>; Silva, Demaris A \*HS <[DAS3AE@uvahealth.org](mailto:DAS3AE@uvahealth.org)>; Canty, James W \*HS

<[JWC4R@uvahealth.org](mailto:JWC4R@uvahealth.org)>; Fawley, Jaclyn <[Jaclyn.Fawley@owens-minor.com](mailto:Jaclyn.Fawley@owens-minor.com)>; O'Connor, Sam <[Sam.O'Connor@owens-minor.com](mailto:Sam.O'Connor@owens-minor.com)>

**Subject:** Fwd: UVA Statement of Account/Hold [External\_Email]

Hi, Holly:

It seems that some orders are still on hold pending the payment for invoice #9026512468. Can you see if this invoice has been paid so we can release orders?

Best,

Courtney

Get [Outlook for iOS](#)

---

**From:** Mendieta Zuniga, Gissell <[gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)>

**Sent:** Monday, November 18, 2024 1:28 PM

**To:** Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>; Castillo Rodriguez, Roque <[roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com)>

**Cc:** Orebaugh, Courtney <[courtney.orebaugh@philips.com](mailto:courtney.orebaugh@philips.com)>; Ervin, Tammy <[tammy.ervin@philips.com](mailto:tammy.ervin@philips.com)>; Skorup, Brian <[brian.skorup@philips.com](mailto:brian.skorup@philips.com)>; Acker, Holly C <[hca3zx@virginia.edu](mailto:hca3zx@virginia.edu)>

**Subject:** RE: UVA Statement of Account/Hold [External\_Email]

Good Morning,

Currently there is no order on hold, everything has been released till last week, however UVA credit limit is on 97%, and there are currently orders on hold, orders won't be released until the overall account AR is decreased.

Is important that we receive payment for invoice #9026512468, please advise if payment was sent last week to our overnight address.

Thank you,

*For Electronic Invoicing just provide your Account Payable email address to me. (working FASTER and SMARTER)*

**Gissell Mendieta**

Account Receivable HS1 - NAM

Global Business Services

Philips Global Business Services, Attn: AR, PO Box 198726, Nashville, TN 37219, USA

Tel: +1 629-262-3692 Email: [gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)

If additional support is needed my manager Roque Castillo can be contacted at [roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com).



---

**From:** Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>

**Sent:** Friday, November 15, 2024 3:20 PM

**To:** Mendieta Zuniga, Gissell <[gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)>; Castillo Rodriguez, Roque <[roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com)>

**Cc:** Orebaugh, Courtney <[courtney.orebaugh@philips.com](mailto:courtney.orebaugh@philips.com)>; Ervin, Tammy <[tammy.ervin@philips.com](mailto:tammy.ervin@philips.com)>; Skorup, Brian <[brian.skorup@philips.com](mailto:brian.skorup@philips.com)>; Acker, Holly C <[hca3zx@virginia.edu](mailto:hca3zx@virginia.edu)>

**Subject:** RE: UVA Statement of Account/Hold [External\_Email]

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Gissell,

Can you confirm that our orders have been released?

**NOTE: UVA Health AP has launched a Solutions Center as the central contact point for AP service inquiries to ensure all your questions are answered promptly. Please direct all your service requests to [RHEALTHAP@uvahealth.org](mailto:RHEALTHAP@uvahealth.org). Requests submitted to the Solutions Center will be prioritized. Thank you!**

Thank you,

**Josia (Josie) Aragon-Harvey**

Accounts Payable Manager

Medical Center | Accounts Payables



---

**From:** Mendieta Zuniga, Gissell <[gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)>

**Sent:** Friday, November 15, 2024 9:38 AM

**To:** Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>; Castillo Rodriguez, Roque <[roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com)>; Emery, Alyssa M \*HS <[esr5xr@uvahealth.org](mailto:esr5xr@uvahealth.org)>; Ask Procurement OPS <[AskProcurementOPS@uvahealth.org](mailto:AskProcurementOPS@uvahealth.org)>

**Cc:** AskFinance <[askfinance@virginia.edu](mailto:askfinance@virginia.edu)>; Orebaugh, Courtney <[courtney.orebaugh@philips.com](mailto:courtney.orebaugh@philips.com)>; Ervin, Tammy <[tammy.ervin@philips.com](mailto:tammy.ervin@philips.com)>; Sydnor, Charles F \*HS <[CFS2AC@uvahealth.org](mailto:CFS2AC@uvahealth.org)>; Skorup, Brian <[brian.skorup@philips.com](mailto:brian.skorup@philips.com)>; Garrison, Misty Lynn \*HS <[MLM9ZA@uvahealth.org](mailto:MLM9ZA@uvahealth.org)>; Mott, Gerome P \*HS <[GM4A@uvahealth.org](mailto:GM4A@uvahealth.org)>; Frank, Matthew J \*HS <[UEZ6JG@uvahealth.org](mailto:UEZ6JG@uvahealth.org)>

**Subject:** RE: UVA Statement of Account/Hold [External\_Email]

**EXTERNAL EMAIL:** This message was sent from outside of UVA Health. Please use caution when replying, clicking links or opening attachments.

Good Morning,

Hi Josie, will review the statement and get back to you.

Our overnight address is:

Overnight:

Fed Ex # 2468-08902

Bank of America

Lockbox Services #100355

6000 Feldwood Rd

College Park, GA 30349

Thank you,

*For Electronic Invoicing just provide your Account Payable email address to me. (working FASTER and SMARTER)*

**Gissell Mendieta**

Account Receivable HS1 - NAM

Global Business Services

Philips Global Business Services, Attn: AR, PO Box 198726, Nashville, TN 37219, USA

Tel: +1 629-262-3692 Email: [gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)

If additional support is needed my manager Roque Castillo can be contacted at [roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com).

---

**From:** Aragon-Harvey, Josie \*HS <[YTD8HZ@uvahealth.org](mailto:YTD8HZ@uvahealth.org)>

**Sent:** Thursday, November 14, 2024 3:59 PM

**To:** Mendieta Zuniga, Gissell <[gissell.mendieta@philips.com](mailto:gissell.mendieta@philips.com)>; Castillo Rodriguez, Roque <[roque.castillorodriguez@philips.com](mailto:roque.castillorodriguez@philips.com)>; Emery, Alyssa M \*HS <[esr5xr@uvahealth.org](mailto:esr5xr@uvahealth.org)>; Ask Procurement OPS <[AskProcurementOPS@uvahealth.org](mailto:AskProcurementOPS@uvahealth.org)>

**Cc:** AskFinance <[askfinance@virginia.edu](mailto:askfinance@virginia.edu)>; Orebaugh, Courtney <[courtney.orebaugh@philips.com](mailto:courtney.orebaugh@philips.com)>; Ervin, Tammy <[tammy.ervin@philips.com](mailto:tammy.ervin@philips.com)>; Sydnor, Charles F \*HS <[CFS2AC@uvahealth.org](mailto:CFS2AC@uvahealth.org)>; Skorup, Brian <[brian.skorup@philips.com](mailto:brian.skorup@philips.com)>; Garrison, Misty Lynn \*HS <[MLM9ZA@uvahealth.org](mailto:MLM9ZA@uvahealth.org)>; Mott, Gerome P \*HS <[GM4A@uvahealth.org](mailto:GM4A@uvahealth.org)>; Frank, Matthew J \*HS <[UEZ6JG@uvahealth.org](mailto:UEZ6JG@uvahealth.org)>

**Subject:** RE: UVA Statement of Account/Hold

**Importance:** High

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## Lynn Swanson

---

**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <AMT6B@uvahealth.org>  
**Sent:** Friday, January 10, 2025 11:35 AM  
**To:** Lynn Swanson  
**Subject:** FW: UVA Update - Account 24447 - Statement Attached.  
**Attachments:** RE: {External} RE: UVA University Hospital - Account 24447 - JUNE 2024 STATEMENT  
\*\*\*\*PROMPT ATTENTION REQUESTED\*\*\*; UVA - Account 24447 - Statement as of  
6-18-2024.xlsx

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**From:** Angela Taylor <tayloram007@gmail.com>  
**Sent:** Friday, January 10, 2025 12:34 PM  
**To:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <AMT6B@uvahealth.org>  
**Subject:** Fwd: FW: UVA Update - Account 24447 - Statement Attached. [External\_Email]

**EXTERNAL EMAIL:** This message was sent from outside of UVA Health. Please use caution when replying, clicking links or opening attachments.

----- Forwarded message -----

**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>  
**Date:** Wed, Nov 13, 2024 at 1:38 PM  
**Subject:** FW: UVA Update - Account 24447 - Statement Attached.  
**To:** Angela Taylor <[tayloram007@gmail.com](mailto:tayloram007@gmail.com)>

---

**From:** Prescott, Jennifer <[Jennifer.Prescott@bsci.com](mailto:Jennifer.Prescott@bsci.com)>  
**Sent:** Thursday, June 20, 2024 12:11 PM  
**To:** Ray, Brittany <[Brittany.Ray@bsci.com](mailto:Brittany.Ray@bsci.com)>  
**Cc:** Prescott, Jennifer <[Jennifer.Prescott@bsci.com](mailto:Jennifer.Prescott@bsci.com)>; BSCI-GetPaid US-SVC <[BSCI-GetPaidUS-SVC@bsci.com](mailto:BSCI-GetPaidUS-SVC@bsci.com)>  
**Subject:** UVA Update - Account 24447 - Statement Attached.

Hi Brittany,

Thank you for the call regarding UVA. Attached is the email sent to Stephanie Shifflett in AP and Josie Aragon-Harvey (AP Manager) on Monday (last email sent to UVA). Also including the updated statement of account from 6/18. I have not received any communications back from Josie or Stephanie since last Thursday 6/13.

\*\*There are several invoices highlighted in orange on the attached statement. These invoices & credits were previously reported as being paid on GHX payments or checks to BSC. Confirmation with GHX and our Cash Team revealed the invoices & credits in question were NOT included in any of the GHX payments or checks to BSC. Last Thursday, 6/13, received an email from Josie stating they identified a system issue where their system was internally offsetting invoices & credits instead of including in payment remits to us. Josie asked at that time if we would allow a list of invoices & credits to be internally offset in our system. We would happily accept this list of invoices & credits to offset to clear some of the past due balance. As of today, this list has not been received from Josie or Stephanie.

There are also a number of invoices where Stephanie has stated the invoices are "In Exception." We need further information on the exceptions, and we are requesting a match exception report from Stephanie and Josie so we can proactively work on any discrepancies on open invoices. No response has been received as of today on the invoices in exception.

Past due invoices are highlighted in yellow on the attached statement. We are requesting all past dues and open credits be resolved & processed for payment as soon as possible to avoid the Credit Hold Warning on Monday 6/24. Account has net 30 day terms and invoices remain open/unpaid thru May 17<sup>th</sup>.

Any assistance you can provide with the account to expedite the offset request AND payments on the past due balances is appreciated.

Thank you,  
Jen



**Jen Prescott**  
Senior Credit & Collections Analyst  
Global Business Services (GBS)

O. 508-382-0312

[Jennifer.prescott@bsci.com](mailto:Jennifer.prescott@bsci.com)  
[www.bostonscientific.com](http://www.bostonscientific.com)

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## Lynn Swanson

---

**From:** Prescott, Jennifer <Jennifer.Prescott@bsci.com>  
**Sent:** Monday, June 17, 2024 8:38 AM  
**To:** Aragon-Harvey, Josie \*HS; Shifflett, Stephanie L \*HS  
**Cc:** Prescott, Jennifer  
**Subject:** RE: {External} RE: UVA University Hospital - Account 24447 - JUNE 2024 STATEMENT  
\*\*\*\*PROMPT ATTENTION REQUESTED\*\*\*\*

Good morning Josie and Stephanie,  
Following up on the list of invoices & credits to offset on the account due to the system glitch. As soon as we receive the list of invoices & credits, the offset will be completed immediately and will allow better visibility on the status of the account.

Thank you,  
Jen

---

**From:** Aragon-Harvey, Josie \*HS <YTD8HZ@uvahealth.org>  
**Sent:** Thursday, June 13, 2024 3:30 PM  
**To:** Prescott, Jennifer <Jennifer.Prescott@bsci.com>; Shifflett, Stephanie L \*HS <SLS8DU@uvahealth.org>  
**Cc:** BSCI-GetPaid US-SVC <BSCI-GetPaidUS-SVC@bsci.com>  
**Subject:** {External} RE: UVA University Hospital - Account 24447 - JUNE 2024 STATEMENT \*\*\*\*PROMPT ATTENTION REQUESTED\*\*\*\*

**CAUTION:** This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe. Be Security Conscious!

Hi Jennifer,

Stephanie and I have been reviewing the statement you sent us earlier today and we discussed a weird glitch in our system. Our system took the credits and offset them with open invoices to equal zero dollars. This caused a payment not to be issued.

If I provide you a list of "payments" our system made, are you able to offset the open credits and invoice in your system?

Thank you,

**Josia (Josie) Aragon-Harvey**  
Accounts Payable Manager

Medical Center | Accounts Payables



---

**From:** Prescott, Jennifer <Jennifer.Prescott@bsci.com>  
**Sent:** Thursday, June 13, 2024 8:14 AM  
**To:** Aragon-Harvey, Josie \*HS <YTD8HZ@uvahealth.org>; Shifflett, Stephanie L \*HS <SLS8DU@uvahealth.org>  
**Cc:** Prescott, Jennifer <Jennifer.Prescott@bsci.com>; BSCI-GetPaid US-SVC <BSCI-GetPaidUS-SVC@bsci.com>

**Subject:** UVA University Hospital - Account 24447 - JUNE 2024 STATEMENT \*\*\*\*PROMPT ATTENTION REQUESTED\*\*\*

**Importance:** High

Good morning Josie and Stephanie,

Attached is the updated statement as of today. Please review and advise on payment status of ALL past due invoices highlighted in yellow. **As of today, past dues are totaling \$971,112.69 (not including open credits totaling (\$154,488.60)). Sales will be notified today of the past due balances on the account; Credit Hold Warning will be issued on 6/24/24 if the past due balance is not resolved.**

Feel free to contact me with any additional questions you may have.

Thank you,  
Jen



**Jen Prescott**

Senior Credit & Collections Analyst  
Global Business Services (GBS)  
O. 508-382-0312

[Jennifer.prescott@bsci.com](mailto:Jennifer.prescott@bsci.com)  
[www.bostonscientific.com](http://www.bostonscientific.com)

For copies of your invoices or to pay a bill online please click [here](#).



[www.bostonscientific.com](http://www.bostonscientific.com)

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Scientific**  
Advancing science for life™

Family View US-- UVA UNIVERSITY HOSPITAL- 0000024447

**Total (Count)** \$2,550,206.39 (587) **Disputed** (\$2,982.83)  
**Overdue** \$764,260.62 **Last Pay** 27,692.83(6/17/24)

Statement as of 6/18/24

Account Name	Account #	Invoice #	Bill Date	PO Number	Reference No	Amount	Ship-ID
UVA UNIVERSITY HOSPITAL	0000024447	990786539	3/17/2023	318544-0002-09	990786539	(\$18,000.00)	060000
UVA UNIVERSITY HOSPITAL	0000024447	990786540	3/17/2023	318543-0002-09	990786540	(\$18,000.00)	060000
UVA UNIVERSITY HOSPITAL	0000024447	990993914	3/28/2023	0002255821	990993914	(\$441.00)	051000
UVA UNIVERSITY HOSPITAL	0000024447	992815264	6/27/2023	318544-0002-10	992815264	(\$21,000.00)	060000
UVA UNIVERSITY HOSPITAL	0000024447	992815265	6/27/2023	318543-0002-10	992815265	(\$21,000.00)	060000
UVA UNIVERSITY HOSPITAL	0000024447	994532940	9/26/2023	318543-0002-11	994532940	(\$13,500.00)	060000
UVA UNIVERSITY HOSPITAL	0000024447	995356125	11/8/2023	0002404670	995356125	\$820.00	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996356732	12/27/2023	0002463469	996356732	\$7,000.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996445692	1/5/2024	0002444091	996445692	\$6,866.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	996482488	1/9/2024	0002446049	996482488	\$397.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996512674	1/10/2024	0002445666	996512674	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	996518857	1/10/2024	2444091	996445692	(\$800.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996531823	1/11/2024	0002447767	996531823	\$282.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996532341	1/11/2024	0002447756	996532341	\$7,317.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996546572	1/11/2024	0002422220	996546572	\$18,595.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996564576	1/12/2024	0002449101	996564576	\$85.24	022000
UVA UNIVERSITY HOSPITAL	0000024447	996571111	1/12/2024	0002449024	996571111	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	996584340	1/15/2024	0002358284	996584340	\$142.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996614562	1/16/2024	0002450783	996614562	\$282.00	035000

UVA UNIVERSITY HOSPITAL	0000024447	996619986	1/16/2024	0002451029	996619986	\$397.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	996637035	1/17/2024	0002451231	996637035	\$6,455.01	035000
UVA UNIVERSITY HOSPITAL	0000024447	996638851	1/17/2024	0002443119	996638851	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	996638912	1/17/2024	0002435279	996638912	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	996644099	1/17/2024	0002451914	996644099	\$227.67	035000
UVA UNIVERSITY HOSPITAL	0000024447	996651464	1/17/2024	0002451934	996651464	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	996652042	1/17/2024	0002448315	996652042	\$614.06	030000
UVA UNIVERSITY HOSPITAL	0000024447	996652043	1/17/2024	0002451914	996652043	\$2,821.33	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996666551	1/18/2024	0002439700	996666551	\$2,371.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	996672580	1/18/2024	0002426316	996672580	\$381.89	035000
UVA UNIVERSITY HOSPITAL	0000024447	996672792	1/18/2024	0002452943	996672792	\$3,948.30	035000
UVA UNIVERSITY HOSPITAL	0000024447	996675572	1/18/2024	0002451690	996675572	\$192.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	996693154	1/19/2024	0002453029	996693154	\$10,074.01	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996697267	1/19/2024	0002453729	996697267	\$2,371.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	996707243	1/19/2024	0002453880	996707243	\$5,966.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996729506	1/22/2024	0002454891	996729506	\$464.94	022000
UVA UNIVERSITY HOSPITAL	0000024447	996731383	1/22/2024	0002455073	996731383	\$3,354.80	035000
UVA UNIVERSITY HOSPITAL	0000024447	996738710	1/22/2024	0002455324	996738710	\$1,522.56	BSC

UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996750668	1/23/2024	0002455422	996750668	\$1,696.73	035000
UVA UNIVERSITY HOSPITAL	0000024447	996753856	1/23/2024	0002456012	996753856	\$929.88	022000
UVA UNIVERSITY HOSPITAL	0000024447	996761236	1/23/2024	0002456290	996761236	\$1,952.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996775036	1/24/2024	0002455292	996775036	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	996775037	1/24/2024	0002449309	996775037	\$381.89	035000
UVA UNIVERSITY HOSPITAL	0000024447	996781842	1/24/2024	0002456997	996781842	\$2,017.24	022000
UVA HAYMARKET MEDICAL CTR	0000372646	996782214	1/24/2024	0002456998	996782214	\$737.00	020000
UVA HAYMARKET MEDICAL CTR	0000372646	996784800	1/24/2024	0002455421	996784800	\$367.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996787662	1/24/2024	0002457129	996787662	\$10,797.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996801733	1/25/2024	0002457555	996801733	\$1,717.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996803333	1/25/2024	0002457688	996803333	\$10,388.00	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996811570	1/25/2024	0002457569	996811570	\$1,317.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996811660	1/25/2024	0002458030	996811660	\$1,803.80	035000
UVA UNIVERSITY HOSPITAL	0000024447	996817346	1/25/2024	0002458176	996817346	\$5,194.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	996828620	1/26/2024	0002458448	996828620	\$1,342.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996835410	1/26/2024	0002457129	996835410	\$176.31	035000
UVA UNIVERSITY HOSPITAL	0000024447	996839201	1/26/2024	0002459021	996839201	\$12,309.50	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996858786	1/29/2024	0002459117	996858786	\$717.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	996864821	1/29/2024	0002460001	996864821	\$350.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996870701	1/29/2024	0002460524	996870701	\$10,335.00	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	996871107	1/29/2024	0002460539	996871107	\$282.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	996874093	1/29/2024	0002460325	996874093	\$9,269.44	035000

UVA UNIVERSITY HOSPITAL	0000024447	996954436	2/1/2024	0002449309	996954436	\$381.89	035000
UVA HAYMARKET MEDICAL CTR	0000372646	996961280	2/1/2024	0002463461	996961280	\$1,717.00	035000
UVA OUTPATIENT SURGERY CENTER	0000167469	996973328	2/2/2024	804335	996973328	\$14,013.80	022000
UVA HAYMARKET MEDICAL CTR	0000372646	996999385	2/5/2024	0002464544	996999385	\$282.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997066342	2/7/2024	0002467356	997066342	\$1,237.00	035000
HAYMARKET SURGERY CENTER	0000373017	997120517	2/9/2024	E4605097	997120517	\$816.82	022000
UVA UNIVERSITY HOSPITAL	0000024447	997249722	2/16/2024	0002473577	997249722	\$425.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997257158	2/17/2024	2421183	995819905	(\$1,000.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257159	2/17/2024	2422533	995850925	(\$895.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257160	2/17/2024	2423463	995875052	(\$250.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257161	2/17/2024	2425490	995935315	(\$1,275.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257162	2/17/2024	2426316	995960565	(\$250.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257163	2/17/2024	2427018	995978660	(\$484.16)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257164	2/17/2024	2425490	996008861	(\$350.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257165	2/17/2024	2428676	996023981	(\$500.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257166	2/17/2024	2427705	996013863	(\$250.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257167	2/17/2024	2428676	996047145	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257168	2/17/2024	2429649	996055320	(\$636.50)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257169	2/17/2024	2430633	996088884	(\$516.50)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257170	2/17/2024	2430335	996076140	(\$242.08)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257171	2/17/2024	2431572	996112667	(\$260.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257172	2/17/2024	2432844	996143743	(\$755.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257173	2/17/2024	2431770	996128899	(\$242.08)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257174	2/17/2024	2433804	996171122	(\$250.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257175	2/17/2024	2426316	996192937	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257176	2/17/2024	2434604	996206817	(\$380.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257177	2/17/2024	2435515	996237193	(\$250.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257178	2/17/2024	2436390	996265982	(\$1,125.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257181	2/17/2024	2426316	996322269	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997257188	2/17/2024	2444108	996440583	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997261494	2/17/2024	2451029	996619986	(\$130.00)	035000

UVA UNIVERSITY HOSPITAL	0000024447	997261496	2/17/2024	2450783	996614562	(\$125.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997261497	2/17/2024	2451914	996652043	(\$500.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997261499	2/17/2024	2452943	996672792	(\$875.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997261501	2/17/2024	2455324	996738710	(\$260.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997261502	2/17/2024	2455073	996731383	(\$255.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278972	2/17/2024	2402917	995286364	(\$130.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278973	2/17/2024	2402896	995285604	(\$405.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278974	2/17/2024	2404378	995329101	(\$195.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278975	2/17/2024	2404379	995329871	(\$130.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278976	2/17/2024	2410152	995497792	(\$125.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997278977	2/17/2024	2412807	995643598	(\$130.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297461	2/17/2024	2424004	995896429	(\$250.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297462	2/17/2024	2429998	996071550	(\$130.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297463	2/17/2024	2432515	996132885	(\$125.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297464	2/17/2024	2443757	996436919	(\$610.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297465	2/17/2024	2444853	996454399	(\$205.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297466	2/17/2024	2447767	996531823	(\$125.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297467	2/17/2024	2447756	996532341	(\$1,420.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297468	2/17/2024	2457569	996811570	(\$350.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297469	2/17/2024	2457555	996801733	(\$405.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297470	2/17/2024	2460539	996871107	(\$125.00)	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997297471	2/17/2024	2467356	997066342	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297472	2/17/2024	2456290	996761236	(\$635.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297475	2/17/2024	2458030	996811660	(\$630.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297476	2/17/2024	2459021	996839201	(\$515.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297477	2/17/2024	2458448	996828620	(\$625.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297478	2/17/2024	2460325	996874093	(\$1,260.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297479	2/17/2024	2461397	996895688	(\$730.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297480	2/17/2024	2462177	996927020	(\$1,000.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297482	2/17/2024	2459021	996944069	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297483	2/17/2024	2464185	996979865	(\$890.00)	035000

UVA UNIVERSITY HOSPITAL	0000024447	997297484	2/17/2024	2465544	997014119	(\$875.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297485	2/17/2024	2466458	997041174	(\$1,885.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297486	2/17/2024	2460325	997025816	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297487	2/17/2024	2461397	997027673	(\$130.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297489	2/17/2024	2467458	997068734	(\$1,375.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997297491	2/17/2024	2468383	997091230	(\$880.00)	035000
UVA HAYMARKET MEDICAL CTR	0000372646	997297492	2/17/2024	2446049	996482488	(\$130.00)	035000
UVA HAYMARKET MEDICAL CTR	0000372646	997297493	2/17/2024	2463461	996961280	(\$405.00)	035000
UVA HAYMARKET MEDICAL CTR	0000372646	997297494	2/17/2024	2464544	996999385	(\$125.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997309435	2/20/2024	0002444091	996445692	(\$505.00)	035000
UVA UNIVERSITY HOSPITAL	0000024447	997333317	2/21/2024	0002470930	997333317	\$18,621.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	997335751	2/21/2024	0002471113	997335751	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	997335752	2/21/2024	0002471114	997335752	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	997336900	2/21/2024	0002471142	997336900	\$1,421.00	060000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	997493162	2/23/2024	0002482157	997493162	\$9,835.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	997537588	3/1/2024	0002484140	997537588	\$1,158.82	022000
UVA UNIVERSITY HOSPITAL	0000024447	997539626	3/1/2024	0002480685	997539626	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	997564445	3/4/2024	0002461397	997564445	\$381.89	035000
UVA UNIVERSITY HOSPITAL	0000024447	997570783	3/4/2024	0002485581	997570783	\$205.34	022000
UVA UNIVERSITY HOSPITAL	0000024447	997599903	3/5/2024	0002486557	997599903	\$1,733.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	997604511	3/5/2024	0002486808	997604511	\$737.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	997611021	3/5/2024	0002486992	997611021	\$2,514.17	010000
UVA UNIVERSITY HOSPITAL	0000024447	997611143	3/5/2024	0002486992	997611143	\$502.83	010000
UVA UNIVERSITY HOSPITAL	0000024447	997723889	3/11/2024	0002490726	997723889	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	997736360	3/12/2024	0002487396	997736360	\$90,000.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	997742404	3/12/2024	0002491432	997742404	\$8,800.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	997782771	3/13/2024	0002477093	997782771	\$31,055.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997810319	3/14/2024	0002493648	997810319	\$1,101.58	012000
UVA UNIVERSITY HOSPITAL	0000024447	997811092	3/14/2024	0002493335	997811092	\$850.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997871149	3/18/2024	0002495906	997871149	\$24,335.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997882936	3/19/2024	0002496654	997882936	\$30,840.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997922266	3/20/2024	0002497999	997922266	\$1,501.32	020000
UVA UNIVERSITY HOSPITAL	0000024447	997923543	3/20/2024	0002493534	997923543	\$26,405.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	997998238	3/25/2024	0002492144	997998238	\$4,339.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	998011032	3/25/2024	0002501112	998011032	\$6,600.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	998027761	3/26/2024	0002496911	998027761	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	998031227	3/26/2024	0002368671	998031227	(\$3,866.10)	054000
UVA UNIVERSITY HOSPITAL	0000024447	998043034	3/26/2024	0002473733	998043034	\$4,421.00	040000

UVA UNIVERSITY HOSPITAL	0000024447	998043035	3/26/2024	0002484696	998043035	\$34,452.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998043036	3/26/2024	0002491754	998043036	\$30,390.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998043037	3/26/2024	0002499621	998043037	\$25,700.00	040000
UVA HAYMARKET MEDICAL CTR	0000372646	998045835	3/26/2024	0002501570	998045835	\$13,200.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	998072982	3/27/2024	0002498880	998072982	\$3,450.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998139232	4/1/2024	UCH00481750	998139232	\$4,819.00	051000
UVA CULPEPER MEDICAL CENTER	0000517943	998166220	4/2/2024	0002506285	998166220	\$500.09	020000
UVA UNIVERSITY HOSPITAL	0000024447	998229607	4/4/2024	0002508793	998229607	\$3,439.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	998286547	4/8/2024	0002422220	998286547	\$18,595.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	998313447	4/9/2024	0002503771	998313447	\$30,055.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998325161	4/10/2024	0002508148	998325161	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	998325162	4/10/2024	0002508165	998325162	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	998334093	4/10/2024	0002511611	998334093	\$3,450.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998334094	4/10/2024	0002510346	998334094	\$6,750.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998381563	4/12/2024	0002508752	998381563	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	998383067	4/12/2024	0002508751	998383067	\$1,421.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	998395785	4/12/2024	0002513254	998395785	\$31,790.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998395786	4/12/2024	0002513557	998395786	\$30,055.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998422151	4/15/2024	0002515633	998422151	\$13,517.48	020000
UVA UNIVERSITY HOSPITAL	0000024447	998424325	4/15/2024	0002515522	998424325	\$31,055.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998444384	4/16/2024	0002516609	998444384	\$1,881.98	022000
UVA UNIVERSITY HOSPITAL	0000024447	998452406	4/16/2024	0002516517	998452406	\$3,777.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998474727	4/17/2024	0002517680	998474727	\$1,962.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	998560486	4/22/2024	0002520179	998560486	\$24,220.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998581365	4/23/2024	0002521439	998581365	\$3,843.19	020000
UVA UNIVERSITY HOSPITAL	0000024447	998583622	4/23/2024	0002521439	998583622	\$1,874.87	020000
UVA UNIVERSITY HOSPITAL	0000024447	998577736	4/24/2024	0002510570	998577736	(\$1,900.00)	020000
UVA UNIVERSITY HOSPITAL	0000024447	998623622	4/24/2024	544609-0001-01	998623622	(\$20,000.00)	065000
UVA HAYMARKET MEDICAL CTR	0000372646	998652992	4/25/2024	0002523234	998652992	\$13,200.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	998705171	4/29/2024	0002518324	998705171	\$30,905.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998790302	5/2/2024	0002526678	998790302	\$30,905.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	998860504	5/7/2024	0002532076	998860504	\$1,837.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	998882177	5/8/2024	0002531531	998882177	\$417.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	998917643	5/9/2024	0002460903	998917643	\$32,009.00	040000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	998917644	5/9/2024	0002460903	998917644	\$31,909.00	040000
PRINCE WILLIAM ASC	0000125055	998965353	5/13/2024	E4768430	998965353	\$663.29	020000
UVA UNIVERSITY HOSPITAL	0000024447	998972379	5/13/2024	0002536058	998972379	\$2,453.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	998993891	5/14/2024	0002534370	998993891	\$1,421.00	060000
UVA HAYMARKET MEDICAL CTR	0000372646	998993959	5/14/2024	0002536553	998993959	\$13,200.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999032990	5/15/2024	0002537988	999032990	\$2,512.14	010000

UVA UNIVERSITY HOSPITAL	0000024447	999056198	5/16/2024	0002539062	999056198	\$3,599.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999079451	5/17/2024	0002539494	999079451	\$1,590.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999079985	5/17/2024	0002539494	999079985	\$636.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999113133	5/20/2024	0002540850	999113133	\$2,591.79	BSC
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999132939	5/21/2024	0002541465	999132939	\$2,371.00	030000
UVA CULPEPER MEDICAL CENTER	0000517943	999133505	5/21/2024	0002541443	999133505	\$116.76	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999134474	5/21/2024	0002541643	999134474	\$2,081.48	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999137023	5/21/2024	0002541445	999137023	\$337.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999137571	5/21/2024	0002541472	999137571	\$747.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999138040	5/21/2024	0002541957	999138040	\$3,137.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999139724	5/21/2024	0002542027	999139724	\$488.80	010000
UVA UNIVERSITY HOSPITAL	0000024447	999142129	5/21/2024	0002541981	999142129	\$2,102.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999144050	5/21/2024	0002542037	999144050	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999146278	5/21/2024	0002542042	999146278	\$177.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999147450	5/21/2024	0002540445	999147450	\$22,350.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	999148241	5/21/2024	0002542078	999148241	\$5,817.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999148242	5/21/2024	0002542179	999148242	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999149208	5/21/2024	0002542180	999149208	\$1,152.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999149209	5/21/2024	0002542174	999149209	\$257.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999163674	5/22/2024	0002542585	999163674	\$1,171.33	030000
UVA UNIVERSITY HOSPITAL	0000024447	999163701	5/22/2024	0002542591	999163701	\$2,182.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999164740	5/22/2024	0002542580	999164740	\$1,732.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999165214	5/22/2024	0002542580	999165214	\$488.80	010000
UVA UNIVERSITY HOSPITAL	0000024447	999169540	5/22/2024	0002540850	999169540	\$1,581.56	012000
UVA UNIVERSITY HOSPITAL	0000024447	999169541	5/22/2024	0002542677	999169541	\$210.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999169551	5/22/2024	0002542675	999169551	\$1,155.31	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999171067	5/22/2024	0002542741	999171067	\$249.47	022000
UVA UNIVERSITY HOSPITAL	0000024447	999172138	5/22/2024	0002542459	999172138	\$1,000.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999172139	5/22/2024	0002542675	999172139	\$227.09	020000
UVA UNIVERSITY HOSPITAL	0000024447	999172918	5/22/2024	0002542817	999172918	\$1,587.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999174181	5/22/2024	0002542813	999174181	\$257.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999175383	5/22/2024	0002542834	999175383	\$7,732.10	035000
UVA UNIVERSITY HOSPITAL	0000024447	999176092	5/22/2024	0002528627	999176092	\$30,055.00	040000
UVA UNIVERSITY HOSPITAL	0000024447	999177113	5/22/2024	0002542893	999177113	\$967.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999177114	5/22/2024	0002542943	999177114	\$1,417.28	030000
UVA UNIVERSITY HOSPITAL	0000024447	999177115	5/22/2024	0002542953	999177115	\$5,022.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999177483	5/22/2024	0002542834	999177483	\$346.80	035000
UVA UNIVERSITY HOSPITAL	0000024447	999177484	5/22/2024	0002542951	999177484	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	999177661	5/22/2024	0002542924	999177661	\$494.88	020000
UVA UNIVERSITY HOSPITAL	0000024447	999177662	5/22/2024	0002542967	999177662	\$1,672.68	020000

UVA HAYMARKET MEDICAL CTR	0000372646	999177741	5/22/2024	0002542756	999177741	\$710.60	035000
UVA UNIVERSITY HOSPITAL	0000024447	999178169	5/22/2024	0002542967	999178169	\$469.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999186621	5/23/2024	0002542979	999186621	\$1,587.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999186622	5/23/2024	0002542978	999186622	\$1,587.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999187896	5/23/2024	0002542585	999187896	\$5,655.67	030000
UVA UNIVERSITY HOSPITAL	0000024447	999187920	5/23/2024	0002539062	999187920	\$765.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999188024	5/23/2024	0002542943	999188024	\$22,609.72	030000
UVA CULPEPER MEDICAL CENTER	0000517943	999188553	5/23/2024	0002543134	999188553	\$156.07	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999189331	5/23/2024	0002543194	999189331	\$666.37	022000
UVA HAYMARKET MEDICAL CTR	0000372646	999189333	5/23/2024	0002543180	999189333	\$832.80	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999190147	5/23/2024	0002543193	999190147	\$265.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999191374	5/23/2024	0002543155	999191374	\$120.24	022000
UVA UNIVERSITY HOSPITAL	0000024447	999191375	5/23/2024	0002543373	999191375	\$5,453.70	020000
UVA UNIVERSITY HOSPITAL	0000024447	999191543	5/23/2024	0002543373	999191543	\$1,246.92	020000
UVA UNIVERSITY HOSPITAL	0000024447	999192402	5/23/2024	0002543380	999192402	\$2,578.31	020000
UVA UNIVERSITY HOSPITAL	0000024447	999192675	5/23/2024	0002543380	999192675	\$551.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999195505	5/23/2024	0002543551	999195505	\$15,126.80	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999196989	5/23/2024	0002543559	999196989	\$551.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999199744	5/23/2024	0002543708	999199744	\$3,980.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999200746	5/23/2024	0002543551	999200746	\$9,768.64	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999203010	5/23/2024	0002543769	999203010	\$2,078.22	020000
UVA UNIVERSITY HOSPITAL	0000024447	999203391	5/23/2024	0002543682	999203391	\$5,945.20	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999203455	5/23/2024	0002543725	999203455	\$903.12	020000
UVA UNIVERSITY HOSPITAL	0000024447	999204062	5/23/2024	0002543788	999204062	\$2,417.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999204696	5/23/2024	0002543289	999204696	\$8,540.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999205656	5/23/2024	0002543711	999205656	\$451.56	020000
UVA UNIVERSITY HOSPITAL	0000024447	999206212	5/23/2024	0002543797	999206212	\$12,292.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999207003	5/23/2024	0002543551	999207003	\$149.06	022000
UVA CULPEPER MEDICAL CENTER	0000517943	999207014	5/23/2024	0002543139	999207014	\$349.86	020000
UVA UNIVERSITY HOSPITAL	0000024447	999189919	5/24/2024	0002543373	999189919	\$1,900.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999215443	5/24/2024	0002540850	999215443	\$1,161.56	012000
UVA UNIVERSITY HOSPITAL	0000024447	999218049	5/24/2024	0002544201	999218049	\$220.34	020000
UVA UNIVERSITY HOSPITAL	0000024447	999218075	5/24/2024	0002542006	999218075	\$180.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999221720	5/24/2024	0002544199	999221720	\$7,865.42	020000
UVA UNIVERSITY HOSPITAL	0000024447	999222489	5/24/2024	0002544381	999222489	\$1,444.96	022000
UVA UNIVERSITY HOSPITAL	0000024447	999225006	5/24/2024	0002544430	999225006	\$1,493.66	010000
UVA UNIVERSITY HOSPITAL	0000024447	999225669	5/24/2024	0002544433	999225669	\$1,372.97	030000
UVA UNIVERSITY HOSPITAL	0000024447	999226120	5/24/2024	0002544256	999226120	\$92.60	022000
UVA UNIVERSITY HOSPITAL	0000024447	999226333	5/24/2024	0002544412	999226333	\$9,624.40	035000
UVA UNIVERSITY HOSPITAL	0000024447	999226334	5/24/2024	0002544430	999226334	\$2,512.14	010000

UVA UNIVERSITY HOSPITAL	0000024447	999229204	5/24/2024	0002544439	999229204	\$802.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999229758	5/24/2024	0002544387	999229758	\$710.28	035000
UVA UNIVERSITY HOSPITAL	0000024447	999230467	5/24/2024	0002543599	999230467	\$17,514.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	999230469	5/24/2024	0002543616	999230469	\$17,510.50	060000
UVA UNIVERSITY HOSPITAL	0000024447	999230752	5/24/2024	0002541385	999230752	\$285,542.00	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999230774	5/24/2024	0002541385	999230774	\$1,795.00	054000
UVA UNIVERSITY HOSPITAL	0000024447	999232462	5/24/2024	0002543599	999232462	\$1,007.00	060000
UVA UNIVERSITY HOSPITAL	0000024447	999232590	5/24/2024	0002543616	999232590	\$1,010.50	060000
UVA UNIVERSITY HOSPITAL	0000024447	999257911	5/28/2024	0002541385	999257911	\$424,434.00	BSC
UVA OUTPATIENT SURGERY CENTER	0000167469	999258493	5/28/2024	0002544730	999258493	\$14,013.80	022000
UVA UNIVERSITY HOSPITAL	0000024447	999260207	5/28/2024	0002545329	999260207	\$19,800.00	022000
UVA HAYMARKET MEDICAL CTR	0000372646	999260249	5/28/2024	0002545378	999260249	\$147.96	022000
UVA HAYMARKET MEDICAL CTR	0000372646	999260833	5/28/2024	0002543179	999260833	\$192.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	999262445	5/28/2024	0002545520	999262445	\$101.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999262593	5/28/2024	0002543290	999262593	\$192.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999263262	5/28/2024	0002544433	999263262	\$5,652.83	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999263273	5/28/2024	0002545305	999263273	\$265.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	999266646	5/28/2024	0002545639	999266646	\$2,942.92	020000
UVA UNIVERSITY HOSPITAL	0000024447	999267003	5/28/2024	0002545784	999267003	\$177.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999268830	5/28/2024	0002545904	999268830	\$1,304.85	022000
UVA UNIVERSITY HOSPITAL	0000024447	999272347	5/28/2024	0002546008	999272347	\$6,107.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999272348	5/28/2024	0002545920	999272348	\$3,629.53	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999272566	5/28/2024	0002546002	999272566	\$657.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999275191	5/28/2024	0002546085	999275191	\$2,770.95	012000
UVA UNIVERSITY HOSPITAL	0000024447	999277407	5/28/2024	0002545987	999277407	\$10,273.70	035000
UVA UNIVERSITY HOSPITAL	0000024447	999277408	5/28/2024	0002546125	999277408	\$3,525.44	020000
UVA UNIVERSITY HOSPITAL	0000024447	999278041	5/28/2024	0002545328	999278041	\$6,000.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999278042	5/28/2024	0002546149	999278042	\$97.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999278043	5/28/2024	0002546154	999278043	\$1,587.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999287375	5/29/2024	0002546156	999287375	\$79,135.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999290651	5/29/2024	0002546487	999290651	\$1,568.76	022000
UVA UNIVERSITY HOSPITAL	0000024447	999290844	5/29/2024	0002546487	999290844	\$4,706.26	022000
UVA UNIVERSITY HOSPITAL	0000024447	999291698	5/29/2024	0002546563	999291698	\$772.40	020000
UVA UNIVERSITY HOSPITAL	0000024447	999291882	5/29/2024	0002543795	999291882	\$183.50	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999293559	5/29/2024	0002546400	999293559	\$2,065.97	022000
UVA UNIVERSITY HOSPITAL	0000024447	999294687	5/29/2024	0002543795	999294687	\$183.50	035000
UVA UNIVERSITY HOSPITAL	0000024447	999294688	5/29/2024	0002546603	999294688	\$417.00	030000
UVA CULPEPER MEDICAL CENTER	0000517943	999294792	5/29/2024	0002543162	999294792	\$185.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999295655	5/29/2024	0002546606	999295655	\$9,552.01	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999296144	5/29/2024	0002546628	999296144	\$2,321.40	020000

UVA UNIVERSITY HOSPITAL	0000024447	999298593	5/29/2024	0002546838	999298593	\$92.60	022000
UVA UNIVERSITY HOSPITAL	0000024447	999299951	5/29/2024	0002546809	999299951	\$386.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999299952	5/29/2024	0002546856	999299952	\$2,289.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999299953	5/29/2024	0002546870	999299953	\$3,047.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999299954	5/29/2024	0002546840	999299954	\$823.80	035000
UVA UNIVERSITY HOSPITAL	0000024447	999300601	5/29/2024	0002546867	999300601	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	999300602	5/29/2024	0002546861	999300602	\$2,587.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999300612	5/29/2024	0002546923	999300612	\$352.47	035000
UVA UNIVERSITY HOSPITAL	0000024447	999301480	5/29/2024	0002546753	999301480	\$1,107.44	022000
UVA UNIVERSITY HOSPITAL	0000024447	999305259	5/29/2024	0002546943	999305259	\$2,846.10	020000
UVA UNIVERSITY HOSPITAL	0000024447	999306378	5/29/2024	0002547072	999306378	\$97.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999306502	5/29/2024	0002547073	999306502	\$737.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999307911	5/29/2024	0002547075	999307911	\$1,911.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999320255	5/30/2024	0002547354	999320255	\$2,596.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	999320489	5/30/2024	0002547473	999320489	\$157.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	999320544	5/30/2024	0002547519	999320544	\$185.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999320643	5/30/2024	0002547352	999320643	\$319.40	022000
UVA UNIVERSITY HOSPITAL	0000024447	999321958	5/30/2024	0002547571	999321958	\$5,294.70	020000
UVA UNIVERSITY HOSPITAL	0000024447	999322031	5/30/2024	0002545904	999322031	\$381.40	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999322438	5/30/2024	0002547525	999322438	\$307.40	020000
UVA UNIVERSITY HOSPITAL	0000024447	999322644	5/30/2024	0002547617	999322644	\$3,602.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999322976	5/30/2024	0002547614	999322976	\$488.80	010000
UVA UNIVERSITY HOSPITAL	0000024447	999322977	5/30/2024	0002547628	999322977	\$7,992.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999323708	5/30/2024	0002547414	999323708	\$42.40	020000
UVA UNIVERSITY HOSPITAL	0000024447	999324341	5/30/2024	0002545920	999324341	\$1,581.18	012000
UVA UNIVERSITY HOSPITAL	0000024447	999325197	5/30/2024	0002547571	999325197	\$802.12	020000
UVA UNIVERSITY HOSPITAL	0000024447	999328884	5/30/2024	0002547930	999328884	\$5,825.10	035000
UVA UNIVERSITY HOSPITAL	0000024447	999334381	5/30/2024	0002547900	999334381	\$262.44	020000
UVA UNIVERSITY HOSPITAL	0000024447	999334739	5/30/2024	0002547900	999334739	\$428.18	022000
UVA UNIVERSITY HOSPITAL	0000024447	999334740	5/30/2024	0002548078	999334740	\$220.34	020000
UVA UNIVERSITY HOSPITAL	0000024447	999336295	5/30/2024	0002547838	999336295	\$3,635.78	022000
UVA UNIVERSITY HOSPITAL	0000024447	999337339	5/30/2024	0002547987	999337339	\$646.09	022000
UVA UNIVERSITY HOSPITAL	0000024447	999346953	5/31/2024	0002547930	999346953	\$178.40	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999348854	5/31/2024	0002548326	999348854	\$981.58	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999350448	5/31/2024	0002548432	999350448	\$1,017.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999350535	5/31/2024	0002547802	999350535	\$5,667.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999350553	5/31/2024	0002548406	999350553	\$192.14	035000
UVA UNIVERSITY HOSPITAL	0000024447	999351272	5/31/2024	0002548527	999351272	\$3,917.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999351288	5/31/2024	0002548453	999351288	\$2,753.12	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999351721	5/31/2024	0002546923	999351721	\$853.85	035000

UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999352081	5/31/2024	0002548395	999352081	\$4,842.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999352082	5/31/2024	0002548530	999352082	\$97.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999352217	5/31/2024	0002548521	999352217	\$97.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999352328	5/31/2024	0002548559	999352328	\$1,300.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999353398	5/31/2024	0002548531	999353398	\$817.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999354582	5/31/2024	0002548560	999354582	\$1,057.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999355422	5/31/2024	0002548669	999355422	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999357475	5/31/2024	0002548518	999357475	\$488.80	010000
UVA HAYMARKET MEDICAL CTR	0000372646	999358410	5/31/2024	0002548712	999358410	\$75.38	035000
UVA UNIVERSITY HOSPITAL	0000024447	999359208	5/31/2024	0002548794	999359208	\$3,544.80	035000
UVA UNIVERSITY HOSPITAL	0000024447	999359209	5/31/2024	0002548747	999359209	\$485.40	022000
UVA UNIVERSITY HOSPITAL	0000024447	999359210	5/31/2024	0002548726	999359210	\$395.00	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999365492	5/31/2024	0002548532	999365492	\$68.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999338875	6/1/2024	0001991097	999338875	\$19,760.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999376297	6/3/2024	0002545639	999376297	\$1,056.30	020000
UVA CULPEPER MEDICAL CENTER	0000517943	999377597	6/3/2024	0002548283	999377597	\$185.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999380861	6/3/2024	0002549713	999380861	\$124.73	022000
UVA HAYMARKET MEDICAL CTR	0000372646	999382413	6/3/2024	0002548394	999382413	\$367.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999383246	6/3/2024	0002549682	999383246	\$3,797.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999383618	6/3/2024	0002549901	999383618	\$1,403.83	022000
UVA UNIVERSITY HOSPITAL	0000024447	999385720	6/3/2024	0002549969	999385720	\$557.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999385789	6/3/2024	0002549987	999385789	\$3,747.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999385790	6/3/2024	0002549977	999385790	\$896.60	030000
UVA UNIVERSITY HOSPITAL	0000024447	999385852	6/3/2024	0002550036	999385852	\$3,600.25	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999386230	6/3/2024	0002549779	999386230	\$666.33	035000
UVA UNIVERSITY HOSPITAL	0000024447	999387282	6/3/2024	0002549867	999387282	\$772.40	020000
UVA UNIVERSITY HOSPITAL	0000024447	999387762	6/3/2024	0002549867	999387762	\$385.36	020000
UVA UNIVERSITY HOSPITAL	0000024447	999387763	6/3/2024	0002550047	999387763	\$386.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999391278	6/3/2024	0002549901	999391278	\$386.51	020000
UVA UNIVERSITY HOSPITAL	0000024447	999391669	6/3/2024	0002550036	999391669	\$25,906.25	035000
UVA UNIVERSITY HOSPITAL	0000024447	999393733	6/3/2024	0002422220	999393733	\$18,595.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999393734	6/3/2024	0002422220	999393734	\$18,595.00	035000
UVA CULPEPER MEDICAL CENTER	0000517943	999404899	6/4/2024	0002550413	999404899	\$1,561.28	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999405822	6/4/2024	0002550669	999405822	\$4,842.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999405946	6/4/2024	0002550492	999405946	\$232.46	022000
UVA UNIVERSITY HOSPITAL	0000024447	999406636	6/4/2024	0002550716	999406636	\$386.20	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999407061	6/4/2024	0002550673	999407061	\$147.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999407227	6/4/2024	0002549983	999407227	\$192.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999407228	6/4/2024	0002550712	999407228	\$302.03	020000
UVA UNIVERSITY HOSPITAL	0000024447	999407472	6/4/2024	0002550712	999407472	\$1,450.00	020000

UVA HAYMARKET MEDICAL CTR	0000372646	999407509	6/4/2024	0002550489	999407509	\$1,591.94	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999408251	6/4/2024	0002550517	999408251	\$609.43	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999408252	6/4/2024	0002550687	999408252	\$200.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	999409287	6/4/2024	0002550489	999409287	\$1,345.67	020000
UVA UNIVERSITY HOSPITAL	0000024447	999411372	6/4/2024	0002550777	999411372	\$1,477.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999412290	6/4/2024	0002550935	999412290	\$900.40	022000
UVA UNIVERSITY HOSPITAL	0000024447	999413098	6/4/2024	0002550773	999413098	\$2,017.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999413099	6/4/2024	0002550972	999413099	\$2,801.23	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999414702	6/4/2024	0002550766	999414702	\$497.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999414703	6/4/2024	0002551016	999414703	\$6,600.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999419612	6/4/2024	0002551221	999419612	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	999420129	6/4/2024	0002551218	999420129	\$1,507.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999420310	6/4/2024	0002551189	999420310	\$2,204.80	010000
UVA UNIVERSITY HOSPITAL	0000024447	999420862	6/4/2024	0002551055	999420862	\$3,762.00	035000
HAYMARKET SURGERY CENTER	0000373017	999420886	6/4/2024	E4804974	999420886	\$99.58	022000
UVA UNIVERSITY HOSPITAL	0000024447	999421851	6/4/2024	0002551223	999421851	\$2,932.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999428779	6/5/2024	0002550036	999428779	\$1,752.50	035000
UVA CULPEPER MEDICAL CENTER	0000517943	999431981	6/5/2024	0002551168	999431981	\$1,500.27	020000
UVA UNIVERSITY HOSPITAL	0000024447	999436370	6/5/2024	0002551440	999436370	\$515.40	022000
UVA UNIVERSITY HOSPITAL	0000024447	999436490	6/5/2024	0002550774	999436490	\$542.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	999436940	6/5/2024	0002551595	999436940	\$648.10	022000
UVA OUTPATIENT SURGERY CENTER	0000167469	999437479	6/5/2024	0002551952	999437479	\$16,174.50	022000
UVA UNIVERSITY HOSPITAL	0000024447	999439684	6/5/2024	0002551822	999439684	\$2,514.17	010000
UVA UNIVERSITY HOSPITAL	0000024447	999442407	6/5/2024	0002551834	999442407	\$3,237.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999442886	6/5/2024	0002551846	999442886	\$307.40	020000
UVA UNIVERSITY HOSPITAL	0000024447	999443083	6/5/2024	0002551809	999443083	\$8,267.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999443228	6/5/2024	0002551827	999443228	\$97.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999443774	6/5/2024	0002551783	999443774	\$1,817.34	020000
UVA UNIVERSITY HOSPITAL	0000024447	999444770	6/5/2024	0002551950	999444770	\$158.46	020000
UVA UNIVERSITY HOSPITAL	0000024447	999446100	6/5/2024	0002551857	999446100	\$1,920.62	020000
UVA UNIVERSITY HOSPITAL	0000024447	999447482	6/5/2024	0002551847	999447482	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999448768	6/5/2024	0002551958	999448768	\$193.46	020000
UVA UNIVERSITY HOSPITAL	0000024447	999448771	6/5/2024	0002552009	999448771	\$1,042.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999448932	6/5/2024	0002551822	999448932	\$3,362.83	010000
UVA UNIVERSITY HOSPITAL	0000024447	999448933	6/5/2024	0002551783	999448933	\$551.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	999449614	6/5/2024	0002422220	999449614	\$18,595.00	035000
UVA CULPEPER MEDICAL CENTER	0000517943	999458458	6/6/2024	0002552211	999458458	\$193.10	020000
UVA CULPEPER MEDICAL CENTER	0000517943	999460227	6/6/2024	0002552212	999460227	\$386.20	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999462049	6/6/2024	0002552306	999462049	\$156.76	020000
UVA UNIVERSITY HOSPITAL	0000024447	999463195	6/6/2024	0002552461	999463195	\$302.03	020000

UVA HAYMARKET MEDICAL CTR	0000372646	999463759	6/6/2024	0002552306	999463759	\$323.30	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999463760	6/6/2024	0002552365	999463760	\$412.20	022000
UVA UNIVERSITY HOSPITAL	0000024447	999464440	6/6/2024	0002552255	999464440	\$6,600.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	999466617	6/6/2024	0002552510	999466617	\$1,414.17	030000
UVA UNIVERSITY HOSPITAL	0000024447	999466618	6/6/2024	0002552515	999466618	\$3,802.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999467571	6/6/2024	0002552598	999467571	\$481.94	022000
UVA UNIVERSITY HOSPITAL	0000024447	999472520	6/6/2024	0002552596	999472520	\$837.47	022000
UVA UNIVERSITY HOSPITAL	0000024447	999472677	6/6/2024	0002552764	999472677	\$156.07	020000
UVA UNIVERSITY HOSPITAL	0000024447	999473493	6/6/2024	0002552720	999473493	\$1,407.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999486267	6/7/2024	0002550972	999486267	\$1,161.56	012000
UVA UNIVERSITY HOSPITAL	0000024447	999486704	6/7/2024	0002552487	999486704	\$16,967.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	999486705	6/7/2024	0002552510	999486705	\$5,652.83	030000
PRINCE WILLIAM ASC	0000125055	999488256	6/7/2024	E4810038	999488256	\$633.29	020000
PRINCE WILLIAM ASC	0000125055	999488635	6/7/2024	E4810038	999488635	\$903.51	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	999489122	6/7/2024	0002553232	999489122	\$1,414.71	020000
UVA UNIVERSITY HOSPITAL	0000024447	999491017	6/7/2024	0002553382	999491017	\$373.44	022000
UVA CULPEPER MEDICAL CENTER	0000517943	999491058	6/7/2024	0002553091	999491058	\$240.34	022000
UVA HAYMARKET MEDICAL CTR	0000372646	999492568	6/7/2024	0002553291	999492568	\$217.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999492791	6/7/2024	0002553507	999492791	\$97.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999494188	6/7/2024	0002553384	999494188	\$557.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	999494927	6/7/2024	0002553637	999494927	\$546.96	020000
UVA HAYMARKET MEDICAL CTR	0000372646	999495508	6/7/2024	0002553628	999495508	\$3,185.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999496895	6/7/2024	0002553588	999496895	\$5,509.01	BSC
UVA UNIVERSITY HOSPITAL	0000024447	999496896	6/7/2024	0002553660	999496896	\$7,856.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	999503809	6/7/2024	0002553774	999503809	\$813.70	020000
UVA UNIVERSITY HOSPITAL	0000024447	700009902	6/10/2024	0002548518	700009902	\$327.60	010000
UVA UNIVERSITY HOSPITAL	0000024447	700010702	6/10/2024	0002554275	700010702	\$124.73	022000
UVA UNIVERSITY HOSPITAL	0000024447	700012587	6/10/2024	0002554538	700012587	\$1,653.60	020000
UVA UNIVERSITY HOSPITAL	0000024447	700013158	6/10/2024	0002554538	700013158	\$2,846.10	020000
UVA UNIVERSITY HOSPITAL	0000024447	700013159	6/10/2024	0002554530	700013159	\$3,148.13	020000
UVA UNIVERSITY HOSPITAL	0000024447	700016840	6/10/2024	0002554530	700016840	\$11,552.08	020000
UVA UNIVERSITY HOSPITAL	0000024447	700016841	6/10/2024	0002554627	700016841	\$1,967.00	030000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700017152	6/10/2024	0002554471	700017152	\$58.30	020000
UVA UNIVERSITY HOSPITAL	0000024447	700018727	6/10/2024	0002554836	700018727	\$1,017.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	700020027	6/10/2024	0002552515	700020027	\$650.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700020028	6/10/2024	0002554845	700020028	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700021141	6/10/2024	0002554826	700021141	\$4,152.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700021308	6/10/2024	0002554872	700021308	\$2,724.92	035000
UVA UNIVERSITY HOSPITAL	0000024447	700023779	6/10/2024	0002553391	700023779	\$192.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700025629	6/10/2024	0002554826	700025629	\$3,500.00	035000

UVA UNIVERSITY HOSPITAL	0000024447	700027063	6/10/2024	0002554953	700027063	\$5,194.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	700027791	6/10/2024	0002554885	700027791	\$440.68	020000
UVA UNIVERSITY HOSPITAL	0000024447	700027792	6/10/2024	0002554952	700027792	\$1,569.63	020000
UVA UNIVERSITY HOSPITAL	0000024447	700026262	6/11/2024	EXPO Catheter Recall	700026262	(\$258.90)	030000
UVA HAYMARKET MEDICAL CTR	0000372646	700040546	6/11/2024	0002555378	700040546	\$1,201.16	022000
UVA UNIVERSITY HOSPITAL	0000024447	700040836	6/11/2024	0002555319	700040836	\$287.98	022000
UVA HAYMARKET MEDICAL CTR	0000372646	700040883	6/11/2024	0002555375	700040883	\$174.90	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700041313	6/11/2024	0002555398	700041313	\$132.50	020000
UVA UNIVERSITY HOSPITAL	0000024447	700042348	6/11/2024	0002555319	700042348	\$2,252.73	022000
UVA UNIVERSITY HOSPITAL	0000024447	700042891	6/11/2024	0002555613	700042891	\$1,397.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700042897	6/11/2024	0002555603	700042897	\$97.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	700043930	6/11/2024	0002555577	700043930	\$217.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700043939	6/11/2024	0002555737	700043939	\$187.98	022000
UVA UNIVERSITY HOSPITAL	0000024447	700044904	6/11/2024	0002554530	700044904	\$166.47	020000
UVA UNIVERSITY HOSPITAL	0000024447	700044905	6/11/2024	0002555737	700044905	\$428.18	022000
UVA UNIVERSITY HOSPITAL	0000024447	700047191	6/11/2024	0002555930	700047191	\$267.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700048332	6/11/2024	0002555955	700048332	\$4,047.01	030000
UVA UNIVERSITY HOSPITAL	0000024447	700048973	6/11/2024	0002555926	700048973	\$371.00	020000
UVA UNIVERSITY HOSPITAL	0000024447	700049201	6/11/2024	0002555897	700049201	\$9,900.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	700049202	6/11/2024	0002555949	700049202	\$1,732.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	700051435	6/11/2024	0002555949	700051435	\$488.80	010000
UVA CULPEPER MEDICAL CENTER	0000517943	700051484	6/11/2024	0002555901	700051484	\$312.14	020000
UVA UNIVERSITY HOSPITAL	0000024447	700053830	6/11/2024	0002555830	700053830	\$700.22	022000
UVA UNIVERSITY HOSPITAL	0000024447	700055813	6/11/2024	0002555886	700055813	\$180.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	700057098	6/11/2024	0002555539	700057098	\$8,142.50	020000
UVA UNIVERSITY HOSPITAL	0000024447	700057468	6/11/2024	0002555931	700057468	\$6,026.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700069234	6/12/2024	0002556500	700069234	\$386.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	700071879	6/12/2024	0002556699	700071879	\$2,752.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700071880	6/12/2024	0002556694	700071880	\$1,985.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700075197	6/12/2024	0002556798	700075197	\$2,070.40	022000
UVA UNIVERSITY HOSPITAL	0000024447	700075971	6/12/2024	0002556954	700075971	\$622.56	030000
UVA UNIVERSITY HOSPITAL	0000024447	700075972	6/12/2024	0002556957	700075972	\$771.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700076988	6/12/2024	0002556951	700076988	\$2,226.20	030000
UVA UNIVERSITY HOSPITAL	0000024447	700081155	6/12/2024	0002556912	700081155	\$2,168.76	020000
UVA UNIVERSITY HOSPITAL	0000024447	700081500	6/12/2024	0002557059	700081500	\$220.34	020000
UVA UNIVERSITY HOSPITAL	0000024447	700082452	6/12/2024	0002557022	700082452	\$614.80	020000
UVA UNIVERSITY HOSPITAL	0000024447	700083689	6/12/2024	0002557118	700083689	\$650.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700084714	6/12/2024	0002556938	700084714	\$4,291.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700084715	6/12/2024	0002557116	700084715	\$682.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700085354	6/12/2024	0002557107	700085354	\$11,340.00	030000

UVA UNIVERSITY HOSPITAL	0000024447	700095290	6/13/2024	0002557325	700095290	\$97.00	030000
UVA HAYMARKET MEDICAL CTR	0000372646	700097816	6/13/2024	0002557450	700097816	\$658.28	020000
UVA UNIVERSITY HOSPITAL	0000024447	700098570	6/13/2024	0002557594	700098570	\$2,663.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	700098571	6/13/2024	0002557720	700098571	\$84.25	030000
UVA HAYMARKET MEDICAL CTR	0000372646	700098805	6/13/2024	0002557450	700098805	\$1,546.42	020000
UVA UNIVERSITY HOSPITAL	0000024447	700099920	6/13/2024	0002557710	700099920	\$2,171.60	022000
UVA UNIVERSITY HOSPITAL	0000024447	700100623	6/13/2024	0002557720	700100623	\$154.50	030000
UVA UNIVERSITY HOSPITAL	0000024447	700102765	6/13/2024	0002557650	700102765	\$4,819.68	020000
UVA UNIVERSITY HOSPITAL	0000024447	700102767	6/13/2024	0002557790	700102767	\$15,747.08	022000
UVA UNIVERSITY HOSPITAL	0000024447	700103248	6/13/2024	0002557724	700103248	\$157.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700105082	6/13/2024	0002557904	700105082	\$1,732.00	010000
UVA UNIVERSITY HOSPITAL	0000024447	700107261	6/13/2024	0002557902	700107261	\$1,400.00	054000
UVA UNIVERSITY HOSPITAL	0000024447	700110699	6/13/2024	0002557929	700110699	\$352.10	020000
UVA UNIVERSITY HOSPITAL	0000024447	700111306	6/13/2024	0002558033	700111306	\$650.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700111558	6/13/2024	0002557936	700111558	\$3,237.18	020000
UVA UNIVERSITY HOSPITAL	0000024447	700111828	6/13/2024	0002557931	700111828	\$13,093.22	035000
UVA UNIVERSITY HOSPITAL	0000024447	700112847	6/13/2024	0002558010	700112847	\$2,198.80	020000
HAYMARKET SURGERY CENTER	0000373017	700112876	6/13/2024	E4822135	700112876	\$192.62	022000
HAYMARKET SURGERY CENTER	0000373017	700113434	6/13/2024	E4822135	700113434	\$6,800.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	700113861	6/13/2024	0002557931	700113861	\$223.89	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700124197	6/14/2024	0002558319	700124197	\$301.04	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700125378	6/14/2024	0002558322	700125378	\$427.76	020000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700125379	6/14/2024	0002558357	700125379	\$967.00	035000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700125380	6/14/2024	0002558447	700125380	\$200.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700125927	6/14/2024	0002558480	700125927	\$386.20	020000
UVA UNIVERSITY HOSPITAL	0000024447	700125928	6/14/2024	0002558477	700125928	\$211.26	020000
UVA HAYMARKET MEDICAL CTR	0000372646	700126618	6/14/2024	0002557353	700126618	\$717.00	035000
UVA HAYMARKET MEDICAL CTR	0000372646	700127076	6/14/2024	0002558356	700127076	\$21,600.00	022000
UVA HAYMARKET MEDICAL CTR	0000372646	700127379	6/14/2024	0002558356	700127379	\$2,400.00	022000
UVA UNIVERSITY HOSPITAL	0000024447	700127406	6/14/2024	0002558552	700127406	\$737.00	010000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700132003	6/14/2024	0002558713	700132003	\$88.70	022000
UVA UNIVERSITY HOSPITAL	0000024447	700133782	6/14/2024	0002558640	700133782	\$1,127.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700133783	6/14/2024	0002558783	700133783	\$557.00	010000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700134942	6/14/2024	0002558715	700134942	\$10,120.19	022000
UVA UNIVERSITY HOSPITAL	0000024447	700134986	6/14/2024	0002558851	700134986	\$651.02	022000
UVA UNIVERSITY HOSPITAL	0000024447	700135727	6/14/2024	0002558821	700135727	\$1,423.05	020000
UVA UNIVERSITY HOSPITAL	0000024447	700137666	6/14/2024	0002558912	700137666	\$2,079.72	020000
UVA UNIVERSITY HOSPITAL	0000024447	700137684	6/14/2024	0002558879	700137684	\$383.66	022000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700142934	6/16/2024	0002556048	700142934	\$4,819.00	051000
UVA UNIVERSITY HOSPITAL	0000024447	700155759	6/17/2024	0002559666	700155759	\$1,450.00	020000

UVA UNIVERSITY HOSPITAL	0000024447	700157302	6/17/2024	0002559672	700157302	\$1,634.76	020000
UVA UNIVERSITY HOSPITAL	0000024447	700157303	6/17/2024	0002559665	700157303	\$1,302.66	020000
UVA UNIVERSITY HOSPITAL	0000024447	700157331	6/17/2024	0002559666	700157331	\$794.16	020000
UVA UNIVERSITY HOSPITAL	0000024447	700157332	6/17/2024	0002559776	700157332	\$124.73	022000
UVA UNIVERSITY HOSPITAL	0000024447	700158400	6/17/2024	0002559739	700158400	\$6,237.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700160216	6/17/2024	0002559735	700160216	\$97.00	030000
UVA UNIVERSITY HOSPITAL	0000024447	700160379	6/17/2024	0002550972	700160379	\$1,581.56	012000
UVA PRINCE WILLIAM MEDICAL CENTER	0000020989	700160743	6/17/2024	0002559652	700160743	\$475.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700162342	6/17/2024	0002560006	700162342	\$2,506.07	010000
UVA UNIVERSITY HOSPITAL	0000024447	700167509	6/17/2024	0002560006	700167509	\$3,550.93	010000
UVA UNIVERSITY HOSPITAL	0000024447	700167772	6/17/2024	0002560062	700167772	\$1,010.50	060000
UVA UNIVERSITY HOSPITAL	0000024447	700168056	6/17/2024	0002560062	700168056	\$17,510.50	060000
UVA UNIVERSITY HOSPITAL	0000024447	700169446	6/17/2024	0002560156	700169446	\$3,913.52	020000
UVA UNIVERSITY HOSPITAL	0000024447	700171779	6/17/2024	0002560009	700171779	\$158.75	030000
UVA UNIVERSITY HOSPITAL	0000024447	700173202	6/17/2024	0002560049	700173202	\$7,448.00	035000
UVA UNIVERSITY HOSPITAL	0000024447	700174192	6/17/2024	0002560014	700174192	\$1,397.00	030000

Due Date	Past Due	Flex Date 2	Payment Status / Comments	Packing Slip #	Tracking #
3/17/2023	459	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset 2/20 GHX EFT REF # 000082 - Stephanie---Credit not included in GHX pymt.		
3/17/2023	459	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset 2/22/24 GHX PYMT REF # 000095 Stephanie --Credit not included in GHX pymt. System issue at UVA		
3/28/2023	448	5/22/2024		0852278437	
6/27/2023	357	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset 2/13/24 GHX PYMT REF # 000047 - STEPHANIE--Credit not included in GHX pymt, system issue		
6/27/2023	357	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset 2/20/24 GHX PYMT REF # 000082 - STEPHANIE --Credit not included in GHX pymt, system issue at UVA		
9/26/2023	266	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset 2/23/24 GHX PYMT REF # 000103 - STEPHANIE, Credit not included in GHX pymt, system issue at UVA		
12/8/2023	193	4/23/2024	4/23/24: Stephanie working on	4332035659	1Z0RX0300337779538
1/26/2024	144	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/12/24 GHX PYMT REF # 000040-STEPHANIE (JP)----Invoice not paid in this GHX pymt, system issue at UVA	4333452245	
2/4/2024	135	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333644269	724012056345
2/8/2024	131	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333709853	1Z0RX0300340347373
2/9/2024	130	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333748942	1Z0RX0300340408235
1/10/2024	160	5/22/2024			
2/10/2024	129	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333780281	1Z0RX0300340434635
2/10/2024	129	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333780188	1Z0RX0300340433967
2/10/2024	129	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333798482	
2/11/2024	128	4/23/2024	4/23/24: Resent inv to Stephanie (JP)	4333828787	1Z0RX0300340522012
2/11/2024	128	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333833540	726006036330
2/14/2024	125	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/9/24 GHX PYMT REF # 000034-STEPHANIE -Inv not paid on this GHX pymt, system issue at UVA	4333836219	1Z0RX0300340546596
2/15/2024	124	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333897713	1Z0RX0300340615163

2/15/2024	124	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/12/24 GHX REF # 000040 - STEPHANIE -Inv not paid on GHX pymt, system issue at UVA	4333904087	1Z0RX0300340639316
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047 - STEPHANIE. Inv not paid on GHX pymt, system issue at UVA.	4333928347	1Z0RX0300340654442
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX REF # 000047 - STEPHANIE -Inv not paid on GHX pymt, system issue at UVA	4333933576	1Z0RX0300340667796
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX REF # 000047 - STEPHANIE. Inv not paid on GHX pymt, system issue at UVA	4333932753	1Z0RX0300340666055
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX REF # 000047 - STEPHANIE (JP)	4333945432	1Z0RX0300340696835
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX REF # 000047 - STEPHANIE (JP)	4333946006	1Z0RX0300340701471
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX REF # 000047 - STEPHANIE (JP)	4333933730	1Z0RX0300340687096
2/16/2024	123	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103-STEPHANIE (JP)	4333944208	1Z0RX0300340696844
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047-STEPHANIE (JP)	4333965552	1Z0RX0300340711853
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047-STEPHANIE (JP)	4333967192	1Z0RX0300340727159
2/17/2024	122	4/23/2024	4/23/24: Exception per Stephanie (JP)	4333985256	1Z0RX0300340758465
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047-STEPHANIE (JP)	4333985939	1Z0RX0300340761504
2/18/2024	121	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047-STEPHANIE (JP)	4334010177	1Z0RX0300340774698
2/18/2024	121	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/13/24 GHX PYMT REF # 000047-STEPHANIE (JP)	4334019117	1Z0RX0300340802157
2/18/2024	121	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 -STEPHANIE (JP)	4334025850	727100397580
2/21/2024	118	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/16/24 GHX PYMT REF # 000058 (JP)	4334059435	1Z0RX0300340858419
2/21/2024	118	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 (JP)	4334065932	1Z0RX0300340878906
2/21/2024	118	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/16/24 GHX PYMT REF # 000058 (JP)	4334070696	727100455977

2/22/2024	117	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/19/24 GHX PYMT REF # 000069 (JP)	4334091884	1Z0RX0300340893836
2/22/2024	117	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/19/24 GHX PYMT REF # 000069 (JP)	4334101475	1Z0RX0300340917766
2/22/2024	117	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334106067	1Z0RX0300340936254
2/23/2024	116	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334118604	1Z0RX0300340948090
2/23/2024	116	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334126062	1Z0RX0300340950498
2/23/2024	116	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334142788	1Z0RX0300340979315
2/23/2024	116	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334142780	1Z0RX0300340979397
2/23/2024	116	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334141531	1Z0RX0300340973642
2/23/2024	116	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334146233	1Z0290030397382421
2/24/2024	115	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334173371	1Z0RX0300341014622
2/24/2024	115	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334176690	1Z0RX0300341020820
2/24/2024	115	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334174245	1Z0RX0300341014980
2/24/2024	115	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/22/24 GHX PYMT REF # 000095 (JP)	4334184435	1Z0RX0300341049461
2/24/2024	115	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334188168	728252098302
2/25/2024	114	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/22/24 GHX PYMT REF # 000095 (JP)	4334211314	1Z0RX0300341071196
2/25/2024	114	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/20/24 GHX PYMT REF # 000082 (JP)	4334219710	1Z0RX0300341099167
2/25/2024	114	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/22/24 GHX PYMT REF # 000095 (JP)	4334222772	1Z0RX0300341110456
2/28/2024	111	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 -STEPHANIE (JP)	4334254504	1Z0RX0300341137375
2/28/2024	111	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 -STEPHANIE (JP)	4334257782	1Z0RX0300341148407
2/28/2024	111	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 -STEPHANIE (JP)	4334270426	728252204348
2/28/2024	111	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334269567	728252203087
2/28/2024	111	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 2/23/24 GHX PYMT REF # 000103 -STEPHANIE (JP)	4334267545	728252192053



2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 11/28/23 CK # 1018937 DALLAS (JP)		
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 12/04/23 check 1019527		
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 12/04/23 check 1019529		
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 12/12/2023 check 1020843		
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 12/19/23 check 1022008		
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 1/9/24 CK 1024717 (JP)		
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 01/12/24 check 1025351		
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 02/02/24 ghx pay eft ref 000007		
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset paid 2/27/24 ghx pymt ref # 000127 (jp)		
2/17/2024	122	6/13/2024			

2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 3/4/24 GHX PYMT REF # 000156 (JP)		
2/17/2024	122	4/23/2024	6/13-Josie (AP Mngr) to send list of CM & INVs to offset PAID 3/4/24 GHX PYMT REF # 000156 (JP)		
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/17/2024	122	6/13/2024			
2/20/2024	119	6/13/2024			
3/22/2024	88	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334937476	1Z0RX0300342170167
3/22/2024	88	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334937473	1Z0RX0300342170658
3/22/2024	88	4/23/2024	4/23/24: Exception per Stephanie (JP)	4334937475	1Z0RX0300342170247
3/22/2024	88	6/13/2024		4334937644	1Z0RX0300342170621
3/24/2024	86	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335011530	
3/31/2024	79	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335228691	1Z0RX0300342599642
3/31/2024	79	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335232857	1Z0RX0300342614517
4/3/2024	76	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335267447	1Z0RX0300342650791
4/3/2024	76	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335279161	1Z0RX0300342685272
4/4/2024	75	6/13/2024		4335319162	1Z0RX0300342737895
4/4/2024	75	6/13/2024		4335325215	1Z0RX0300342758998
4/4/2024	75	6/13/2024		4335329218	732332260466
4/4/2024	75	6/13/2024		4335330711	732332261521
4/10/2024	69	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335499785	733819892997
4/11/2024	68	6/13/2024			
4/11/2024	68	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335522435	733819906493
4/12/2024	67	6/13/2024		4334860969	
4/13/2024	66	6/13/2024		4335620107	
4/13/2024	66	6/13/2024		4335612447	1Z0RX0300343180047
4/17/2024	62	6/13/2024		4335643802	
4/18/2024	61	6/13/2024		4335685104	
4/19/2024	60	4/23/2024	4/23/24: Exception per Stephanie (JP)	4335772498	1Z0RX0300343431089
4/19/2024	60	6/13/2024		4335570495	
4/24/2024	55	6/13/2024		4335859404	735594339731
4/24/2024	55	6/13/2024		4335902717	735594364250
4/25/2024	54	6/13/2024		4335935324	1Z0RX0300343639329
3/26/2024	84	6/13/2024		0853243376	
4/25/2024	54	6/13/2024		4334658465	

4/25/2024	54	6/13/2024		4335186010	
4/25/2024	54	6/13/2024		4335498140	
4/25/2024	54	6/13/2024		4335808980	
4/25/2024	54	6/13/2024		4335931215	735594392776
4/26/2024	53	6/13/2024		4335764434	
5/1/2024	48	6/13/2024		4336082152	
5/2/2024	47	6/13/2024		4336119644	1Z01AV210309753477
5/4/2024	45	6/13/2024		4336205159	737257673003
5/8/2024	41	6/13/2024		4336288695	
5/9/2024	40	6/13/2024		4335983043	
5/10/2024	39	6/13/2024		4336329077	1Z0RX0300344288715
5/10/2024	39	6/13/2024		4336329659	1Z0RX0300344288813
5/10/2024	39	6/13/2024		4336305631	
5/10/2024	39	6/13/2024		4336308557	
5/12/2024	37	6/13/2024		4336429711	1Z0RX0300344438517
5/12/2024	37	6/13/2024		4336429692	1Z0RX0300344438482
5/12/2024	37	6/13/2024		4336306988	
5/12/2024	37	6/13/2024		4336358176	
5/15/2024	34	6/13/2024		4336477501	1Z0RX0300344539355
5/15/2024	34	6/13/2024		4336430861	
5/16/2024	33	6/13/2024		4336516109	1Z0RX0300344599684
5/16/2024	33	6/13/2024		4336478552	
5/17/2024	32	6/13/2024		4336558553	1Z0RX0300344674520
5/22/2024	27	6/13/2024		4336624476	
5/23/2024	26	6/13/2024		4336715671	1Z0RX0300344910792
5/23/2024	26	6/13/2024		4336710752	1Z01AV210310270692
4/24/2024	55	6/13/2024		0853320963	
4/24/2024	55	6/13/2024	Rebate Credit		
5/25/2024	24	6/13/2024		4336787547	740167033030
5/29/2024	20	6/13/2024		4336557492	
6/1/2024	17	6/13/2024		4336876407	
6/6/2024	12	6/13/2024		4337106630	1Z0RX0300345661792
6/7/2024	11	6/13/2024		4337128024	1Z0RX0300345678275
6/8/2024	10	6/13/2024		4333237337	
6/8/2024	10	6/13/2024		4333460878	
6/12/2024	6	6/13/2024		4337265357	1Z0RX0300345941533
6/12/2024	6	6/13/2024		4337269357	1Z0RX0300345954252
6/13/2024	5	6/13/2024		4337306808	1Z0RX0300346010608
6/13/2024	5	6/13/2024		4337298654	743744881234
6/14/2024	4	6/13/2024		4337350439	1Z0RX0300346094046

6/15/2024	3	6/13/2024		4337389127	1Z0290030390641314
6/16/2024	2	6/13/2024		4337423554	1Z0RX0300346205283
6/16/2024	2	6/13/2024		4337421960	1Z0RX0300346205309
6/19/2024	-1	6/13/2024		4337464358	743904871327
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6/20/2024	-2	6/13/2024		4337497763	1Z01AV210310975850
6/20/2024	-2	6/13/2024		4337500458	1Z0RX0300346354541
6/20/2024	-2	6/13/2024		4337494771	1Z0RX0300346336605
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6/20/2024	-2	6/13/2024		4337507171	1Z0RX0300346378365
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6/21/2024	-3	6/13/2024		4337553962	1Z0RX0300346464002
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6/23/2024	-5	6/13/2024		4337631045	1Z0RX0300346587737
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6/23/2024	-5	6/13/2024		4337630156	1Z0RX0300346587120
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6/27/2024	-9	6/13/2024		4337687734	
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BRITTANY RAY

# **APPENDIX, DOCUMENT #21**



Outlook

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**FW: Two monocular patients mismanaged by call center.**

---

From Yates, Paul A \*HS <PAY2X@uvahealth.org>

Date Wed 8/24/2022 7:24 PM

To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS

Sent: Tuesday, January 26, 2021 2:19 PM

To: Shildkrot, Yevgeniy \*HS <YS8Q@hscmail.mcc.virginia.edu>

Cc: Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Prum, Bruce E \*HS <BEP2Z@hscmail.mcc.virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>; Peddada, Krishi \*HS <KP3DK@hscmail.mcc.virginia.edu>; CL EYE FACULTY <CLEYEFACULTY@hscmail.mcc.virginia.edu>; Saavedra, Arturo P \*HS <AS4DA@hscmail.mcc.virginia.edu>; Orange Jr, Vincent \*HS <VO7CE@hscmail.mcc.virginia.edu>; Gonnella, John B \*HS <JBG9W@hscmail.mcc.virginia.edu>

Subject: Re: Two monocular patients mismanaged by call center.

As I stated last night during our faculty meeting and will reiterate today, the purpose I presume in reorganizing our call center was to bring into line with the rest of the medical center and to streamline our concept of "patient friendly access". Unfortunately this reorganization has resulted in far worse patient care, not improved patient care. Our calls are being mismanaged, our patients are unhappy, and we are as Dr Shildkrot stated placing all physicians that have to deal with the consequences of this mismanagement at significant medico legal liability. Our job should not be to streamline operations at the expense of excellent patient care. We are falling severely short on what should be the core focus of our mission as a hospital. I would hope this is quickly recognized and immediately rectified.

Paul

Sent from my iPhone

> On Jan 26, 2021, at 1:51 PM, Shildkrot, Yevgeniy \*HS <YS8Q@hscmail.mcc.virginia.edu> wrote:

>

> Hi Team,

>

> To follow-up on Pauls' several reports of grossly mismanaged patient calls, I wanted to address two additional encounters from the last week. This does not included a multitude of mismanaged calls, some of which I have brought to the attention of the team previously. I am including Art on this as he is likely to be our point person on ambulatory issues. Art, since our patient scheduling and communication was taken over by medical center, we have had an disturbing pattern of visually threatening emergent issues mismanaged and that pattern continues.

>  
 > Our well established coordinated system of patient triage and admins addressing patient concerns with backup trained individuals was taken from us and placed into the team with minimal knowledge or experience and minimal understanding of nuances of subspecialties in ophthalmology.. To use yesterday's analogy (from faculty meeting), our experienced quarterbacks were placed into high school football teams and told to play in the superball - they are in way over their head and our patients are suffering.

>  
 > Just two examples from last week for Me (multiple others were mentioned by other faculty)

>  
 > 1. [REDACTED]  
 > - Monocular patient who I referenced yesterday in our faculty meeting  
 > - Called 1/19/21 8:44 am - Daughter called saying the patient lost vision 24 hours ago, flashes - epic encounter placed into the system  
 > - No one addressed this,  
 > - the patient called 1/20/21 - still with symptoms, Daughter is very concerned of losing vision and no one called back \_ at this point no page or phone call was made, No offer of patient to come through emergently was made  
 > - The patient ultimately came in to see me on 1/22 in the afternoon  
 > with a nearly complete detachment of her only seeing eye  
 > - I had to rush her to surgery in the middle of the night to try to save the vision

>  
 > I am not sure what knowledge or information is needed to have this addressed properly - my Team would have known to have the patient come in. I WAS IN THE CLINIC ALL DAY ON 1/20/21!! My former admin had no issues placing the patient in, calling or texting me or otherwise making sure the patient was taken care of - because she CARES!

>  
 > If I was a lawyer reading this for a law suit - this would be completely @ fault for the Medical center. If the team does not care about patients or their well being, perhaps legal issues would get through better. I am asking our legal department to review this case because of the potential for liability.

>  
 >  
 >  
 >  
 > 2. [REDACTED]  
 > Shared Patient between Dr Prum and me.  
 >  
 > [REDACTED] called 3!! times to address acute change in vision in her  
 > only seeing eye (called 434-+924-2808, dialed from 434-401-2727)  
 >  
 > Called on Friday AM - was told someone will get back with her - no documentation no encounter no epidc notes Called On Monday AM again -  
 > same story no documentation Called on Monday PM, worried - told that it will be escalated and Dr Peddada reached back to her.

>  
 > Where do I even begin??? Is there an effort to fully blind our patients??? - That's 2 monocular

patients Last week!!!

>

> And these are the patients who actually do call back or persist, waiting on HOLD every time they call for a while....

>

> Several aspects:

>

> 1. Eye disease does not occur on business days only - if you drop the ball on friday - the patient may be irreversably blind by Monday

> 2. There is ZERO accountability in the current call center. In the past, My staff would follow-up up on patients they are worried about to enusre they have been reached

> - currently, the apparent policy is: once the staff hang up the phone

> - the patient and their issues are out of mind.... THIS IS NOT how we have run the clinic and this is NOT ACCEPTABLE to be occuring 3. There is a definite perception from the call center that the physicans sit by their computers checking their epic all day - We do NOT! We run around from patient to patient, from surgery to surgery,. We document encounters, follow-up on testing, write letters etc - We do not review the epic inbox and it is not to be used for urgent follow-ups. Epic inbox as the ONLY mode of coummunicatoin. is only appropriate for things that can wait for 2-3 day.

>

>

> Eugene Y. Shildkrot, M.D.

> Associate Professor of Ophthalmology

> Ocular Oncology

> Vitreoretinal Diseases and Surgery

> University of Virginia

> 434-924-5653

# **APPENDIX, DOCUMENT #22**



Outlook

FW: [REDACTED]

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From Yates, Paul A \*HS <PAY2X@uvahealth.org>

Date Wed 8/24/2022 7:23 PM

To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS

Sent: Tuesday, January 26, 2021 10:37 AM

To: Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Peddada, Krishi \*HS <KP3DK@hscmail.mcc.virginia.edu>; Shildkrot, Yevgeniy \*HS <YS8Q@hscmail.mcc.virginia.edu>; Zhang, Alice Y \*HS <AZ3JF@hscmail.mcc.virginia.edu>  
Subject: [REDACTED]

Patient called a month ago 12/17/20 twice to schedule urgent appoint for "eye infection". Message was left in Epic chart x 1 to our fellow and copied to me. It was not returned by Dr Peddada or myself. On this one I am going to take responsibility because the buck stops here. In general we have an expectation the fellow will return Epic messages and in this instance it didn't happen. It falls on me to ensure that.

All this said, I believe this approach of relying on an Epic message to communicate between our call center and the physician or fellow, especially when there may be an urgent issue to address (in this case it was a styte but it could easily have been something worse) just should not be considered an acceptable or reliable approach. It is the equivalent of moving something from the inbox to the outbox and washing ones hands of it. We have seen multiple instances of potentially major mistakes made with this handoff approach. Until the message is acknowledged, it needs to firmly sit in the court of our call center. Epic is not the solution for communication, and especially urgent communication.

The only part of this I am going to put on the call center, is that when a patient calls back a second time and it is not escalated, this is a cause for concern. If a patient requests an appointment, put one in, and deal with the repercussions of that later. None of our staff mind being paged directly to answer urgent scheduling questions, and to not use this tool is missing an opportunity to actually achieve what we are calling "patient friendly" access.

Paul

Sent from my iPhone

# **APPENDIX, DOCUMENT #23**



Outlook

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**FW: Two monocular patients mismanaged by call center.**

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From Yates, Paul A \*HS <PAY2X@uvahealth.org>

Date Wed 8/24/2022 7:24 PM

To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS

Sent: Tuesday, January 26, 2021 2:19 PM

To: Shildkrot, Yevgeniy \*HS <YS8Q@hscmail.mcc.virginia.edu>

Cc: Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Prum, Bruce E \*HS <BEP2Z@hscmail.mcc.virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>; Peddada, Krishi \*HS <KP3DK@hscmail.mcc.virginia.edu>; CL EYE FACULTY <CLEYEFACULTY@hscmail.mcc.virginia.edu>; Saavedra, Arturo P \*HS <AS4DA@hscmail.mcc.virginia.edu>; Orange Jr, Vincent \*HS <VO7CE@hscmail.mcc.virginia.edu>; Gonnella, John B \*HS <JBG9W@hscmail.mcc.virginia.edu>

Subject: Re: Two monocular patients mismanaged by call center.

As I stated last night during our faculty meeting and will reiterate today, the purpose I presume in reorganizing our call center was to bring into line with the rest of the medical center and to streamline our concept of "patient friendly access". Unfortunately this reorganization has resulted in far worse patient care, not improved patient care. Our calls are being mismanaged, our patients are unhappy, and we are as Dr Shildkrot stated placing all physicians that have to deal with the consequences of this mismanagement at significant medico legal liability. Our job should not be to streamline operations at the expense of excellent patient care. We are falling severely short on what should be the core focus of our mission as a hospital. I would hope this is quickly recognized and immediately rectified.

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 > Shared Patient between Dr Prum and me.  
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 > [REDACTED] called 3!! times to address acute change in vision in her  
 > only seeing eye (called 434-+924-2808, dialed from 434-401-2727)  
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 > Called on Friday AM - was told someone will get back with her - no documentation no encounter no epidc notes Called On Monday AM again -  
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>

>

> Eugene Y. Shildkrot, M.D.

> Associate Professor of Ophthalmology

> Ocular Oncology

> Vitreoretinal Diseases and Surgery

> University of Virginia

> 434-924-5653

# **APPENDIX, DOCUMENT #24**



Outlook

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**FW: PFA triage**

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**From** Yates, Paul A \*HS <PAY2X@uvahealth.org>  
**Date** Wed 8/24/2022 7:20 PM  
**To** Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

**From:** Yates, Paul A \*HS  
**Sent:** Thursday, April 1, 2021 11:44 AM  
**To:** Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>  
**Cc:** Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>  
**Subject:** PFA triage

Let me be more specific here.

You have a PFA system that is entirely single point failure here. Now you inherited a system that was also single point failure. The difference is that the people answering the phones, and potentially asked to deal with an escalatable concern, had done so for years in that specific domain. They rarely got it wrong.

From a safety perspective a single point failure system is fraught with exactly the issues you have experienced. This is especially true for those with no domain knowledge as we have transitioned to . This is entirely predictable. I am surprised and concerned that this was not recognized previously, but it is what it is.

The core problem is that we are taking an approach that will eventually rely on our unknowledgeable PFA representatives following to the letter a preset script and flowchart. Most will, but after doing this for several weeks or months they will start skipping the script. Happens with everyone. And then we will see this again.

In most other practices there is a triage position. The only question a PFA associate has to ask is "are you experiencing any new symptoms or problems?". First question and only question that need be asked. That's a script everyone can follow. It's like saying "hello ? "

It then goes to the triage person who by definition knows they have an escalatable problem to deal with and very likely won't screw it up with a) actual knowledge and b) a script that has to be filled out for each call.

I call my pediatrician (as we did for my daughter this weekend who was having cold versus covid), we have a call back from the nurse call center in Charlotte or UVAs own nurse practitioners

I am going to assert, without proof mind you, that if this approach had been taken from the beginning as

we requested occur, we would not be faced with any of what we are seeing now.

To put this into perspective we have almost the same system that TSA uses. A single airport screening agent is tasked with identifying any concerning baggage contents. And it will be one bag out of 1000 that has anything. Study after study has shown that this approach inevitably fails both due to exhaustion, boredom, and losing any enhanced sense of awareness when this is your job every day 40 hours a week. You will inevitably miss the weapon that sneaks thru the baggage system.

At least I finally have an acknowledgement that you both know there is a problem. I do not have certainty that you yet know what the solution actually is here. That remains incredibly concerning.

Paul

# **APPENDIX, DOCUMENT #25**



Outlook

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**FW: Substantial ongoing issues with PFA in Ophthalmology**

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From Yates, Paul A \*HS <PAY2X@uvahealth.org>

Date Wed 8/24/2022 7:25 PM

To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS

Sent: Wednesday, February 10, 2021 12:50 PM

To: Horton, Wendy M \*HS <WMH7R@hscmail.mcc.virginia.edu>

Cc: Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Eugene Shildkrot <shildkrot@virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>; Chhabra, Bobby \*HS <AC2H@hscmail.mcc.virginia.edu>; Kent, Craig \*HS <CK8AQ@hscmail.mcc.virginia.edu>

Subject: Substantial ongoing issues with PFA in Ophthalmology

Dr Horton,

I apologize upfront for intruding into your day, but this issue is not being resolved working through lower channels and it is of I believe an urgent nature.

As you may know ophthalmology recently fully moved over to a pod system for its implementation of patient friendly access. Our admin's were removed, and transferred to this pod, serving it in a generic rather than subspecialty specific manner.

One understands that in implementing any new system, there will be hiccups. But I believe it is not understatement to say that our implementation has been a downright disaster, with multiple near mid air collisions. We have had over the last two months almost a dozen patients with vision threatening emergent conditions handled in a completely inappropriate manner, by untrained access associates. We have had less emergent patients expressed to us directly their frustration in reaching anyone competent to answer their questions and disposition their problem.

We had a significant faculty meeting with Vincent Orange, Rachel Boston, Kim Pate, and Katie Fellows a couple of weeks ago and expressed the urgency of the four alarm fire going off. However, the subsequent report issued by this group on one of my patients who was (but for my own patients efforts to correct the associate) almost scheduled two months after their necessary treatment shows unfortunately there was a tone deafness to understanding either the gravity or the complexity of the situation. The net conclusion was that the patient's appointment was not entered into epic, not but the patient was scheduled almost 2 months after when they should've been, when we were in fact calling the patient to reschedule their appointment initially.

This week Dr. Shildkrot had yet another patient who needed emergent intervention for a retinal detachment messaged to him through Epic as if one was messaging with the same urgency for a

medication refill. This occurred despite our vehemently expressed reservations to this inadequate mode of communicating urgent patient issues to providers. This is but one of many such incidents.

We risk as providers substantial liability if this process goes wrong. Patient friendly access means nothing if it compromises the safety of our patient care. This issue needs to be urgently addressed and rectified since we experienced almost none of these issues prior to implementation of this system. I fear that the current team in charge does not understand, is not capable, and will not fix this problem in a timely manner. I wished to give them a chance, but when these episodes keep occurring, time has run out.

Anyone who knows me as well as the other providers in our department knows that patient safety and satisfaction is of paramount concern. I would not be raising this to your level if it were not for that and it was simply a disagreement of protocol and procedure.

I wished to work through the system and give them a chance to see the error of their process and yet it continues. I am hopeful that you can step in here and please address this immediately. I am more than happy to meet with you personally as I know are multiple members of our faculty if you need further details of what has transpired with the loss of our admin's and the generic answering a phone calls from our patients without adequate knowledge to appropriately disposition and communicate their issues.

Thank you in advance for your attention to this matter.

Paul Yates

Associate Professor of Ophthalmology

Sent from my iPhone

# **APPENDIX, DOCUMENT #26**



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**FW:** [REDACTED]

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**From** Yates, Paul A \*HS <PAY2X@uvahealth.org>  
**Date** Wed 8/24/2022 7:19 PM  
**To** Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

**From:** Yates, Paul A \*HS  
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**To:** Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>  
**Cc:** Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>  
**Subject:** Re: [REDACTED]

I appreciate the detailed report.

As you will well note, Dr Kirzhner had another significant PFA issue with another patient yesterday.

Kim and Katie nobody doubts your (or John's) concern and the importance you place on solving this problem here. The issue is that the procedures that have been put in place thus far continue to result in a lack of recognition of the need for escalation and the timeliness of doing so. I can only reiterate that prior to PFA the frequency of such episodes was significantly below what it has been most recently.

It is hard to believe in a new process when that new process has seemingly had these repercussions to our patients. Domain specific expertise matters, and when we have such a sieve of a safety net here we need to seriously question whether the decided upon approach is actually the correct approach to take. I and I presume many of the faculty remain skeptical to say the least.

The burden of proof resides with both of you. The results thus far are not on your side here.

Paul

Sent from my iPhone

> On Apr 1, 2021, at 10:26 AM, Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu> wrote:  
>  
> Good morning Dr. Olsakovsky and Dr. Yates,  
>  
> I apologize for the delay in responding. Since Dr. Yates copied PLT, I wanted to ensure Kim Daniels and Dr. Netland have an understanding of the results of the investigation. I spoke with Kim yesterday and I have been playing phone tag with Dr. Netland. I hope I to speak with him today.  
>

> We listened to the call and spoke with the team member who took the call. On March 8th, [REDACTED] called to ask about his appointment date. John shared that it was April 27th. [REDACTED] then asked if he could move it up as he was not able to see out of his good eye. John found an appointment on March 26th. The patient accepted the new date and hung up. John failed to hear and recognize the need for immediate escalation.

>

> When we discussed this with John on Monday morning, he immediately recognized his error and took full responsibility. We have reiterated with the team any language regarding losing sight needs immediate escalation. In addition, we have changed our standard work such that when a patient calls to reschedule his/her appointment, we will document the reason for the reschedule in the reschedule reason comments. Our expectation is that when the team has to enter this information, it is a safety net opportunity to again ask what is happening.

>

> John, Kim and I are deeply sorry for this error.

>

> Thanks, Katie

>

> -----Original Message-----

> From: Olsakovsky, Leslie \*HS

> Sent: Thursday, April 1, 2021 9:40 AM

> To: Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Yates, Paul A \*HS <PAY2X@hscmail.mcc.virginia.edu>; Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>

> Subject: RE: [REDACTED]

> Importance: High

>

> Hello,

>

> It has been 6 days and I have not heard a report back about what happened with this patient and the original phone call into the department.

>

> Can I please have the details?

>

> L

>

> -----Original Message-----

> From: Fellows, Katherine H \*HS

> Sent: Friday, March 26, 2021 3:45 PM

> To: Yates, Paul A \*HS <PAY2X@hscmail.mcc.virginia.edu>; Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Daniels, Kimberlee Y \*HS <KYD5W@hscmail.mcc.virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>

> Cc: Cusick, Michael \*HS <MC9CR@hscmail.mcc.virginia.edu>; Eugene Shildkrot <shildkrot@virginia.edu>; Horton, Wendy M \*HS <WMH7R@hscmail.mcc.virginia.edu>; Gehle, Bruce \*HS <BDG5QR@hscmail.mcc.virginia.edu>; White, Skip \*HS <ROW9C@hscmail.mcc.virginia.edu>

> Subject: RE: [REDACTED]

>

> Thank you Dr. Yates for the email. I communicated with Kim Pate. She is investigating the situation now.

>

> I would ask that we report back on Monday so we have an opportunity to be thorough in our data gathering and review.

>

> Thanks, Katie

>

>

> -----Original Message-----

> From: Yates, Paul A \*HS

> Sent: Friday, March 26, 2021 3:30 PM

> To: Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Daniels, Kimberlee Y \*HS <KYD5W@hscmail.mcc.virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>

> Cc: Cusick, Michael \*HS <MC9CR@hscmail.mcc.virginia.edu>; Eugene Shildkrot <shildkrot@virginia.edu>; Horton, Wendy M \*HS <WMH7R@hscmail.mcc.virginia.edu>; Gehle, Bruce \*HS <BDG5QR@hscmail.mcc.virginia.edu>; White, Skip \*HS <ROW9C@hscmail.mcc.virginia.edu>

> Subject: [REDACTED]

>

> Monocular patient called in 1 month ago, stating his vision had decreased and he only had one good eye. Was told that the earliest he could see me was a month later. Vision was 20/50 on 10/27/2020, vision today is 20/200 -legally blind.

>

> The plane has finally crashed. A Be Safe will be formally filed on this one. I seriously hope a root cause analysis is performed here and that there are some repercussions to be had. There is no documentation of his call to us whatsoever in Epic.

>

> I want to understand from this analysis:

>

> 1) who took the phone call in the first place ?

> 2) why was the phone call with vision loss (stated per the patient directly to the person answering the phone call) not immediately referred to any eye care provider - the urgency was no mystery here as the patient stated it himself ?

> 3) why is it that I keep hearing from my patients that my availability is a month or more out when I have clinics routinely well below my template ? Where is this information coming from ?

> 4) who is going to actually be held finally accountable for this ? I told you the plane would crash, the plane has now finally crashed and we don't get a do over here unfortunately.

>

> This outcome has been entirely predictable. But as long a no bad outcome was to be had yet, the five alarm fire was addressed in a less than emergent manner. I am disappointed that our approach has led to my patient now being blind.

>

> Paul

>

> Sent from my iPhone

# **APPENDIX, DOCUMENT #27**



Outlook

FW: [REDACTED]

From Yates, Paul A \*HS <PAY2X@uvahealth.org>  
Date Wed 8/24/2022 7:17 PM  
To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS  
Sent: Friday, March 26, 2021 3:30 PM  
To: Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>; Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Olsakovsky, Leslie \*HS <LA05Q@hscmail.mcc.virginia.edu>; Daniels, Kimberlee Y \*HS <KYD5W@hscmail.mcc.virginia.edu>; Netland, Peter A \*HS <PAN9C@hscmail.mcc.virginia.edu>  
Cc: Cusick, Michael \*HS <MC9CR@hscmail.mcc.virginia.edu>; Eugene Shildkrot <shildkrot@virginia.edu>; Horton, Wendy M \*HS <WMH7R@hscmail.mcc.virginia.edu>; Gehle, Bruce \*HS <BDG5QR@hscmail.mcc.virginia.edu>; White, Skip \*HS <ROW9C@hscmail.mcc.virginia.edu>  
Subject: [REDACTED]

Monocular patient called in 1 month ago, stating his vision had decreased and he only had one good eye. Was told that the earliest he could see me was a month later. Vision was 20/50 on 10/27/2020, vision today is 20/200 -legally blind.

The plane has finally crashed. A Be Safe will be formally filed on this one. I seriously hope a root cause analysis is performed here and that there are some repercussions to be had. There is no documentation of his call to us whatsoever in Epic.

I want to understand from this analysis:

- 1) who took the phone call in the first place ?
- 2) why was the phone call with vision loss (stated per the patient directly to the person answering the phone call) not immediately referred to any eye care provider - the urgency was no mystery here as the patient stated it himself ?
- 3) why is it that I keep hearing from my patients that my availability is a month or more out when I have clinics routinely well below my template ? Where is this information coming from ?
- 4) who is going to actually be held finally accountable for this ? I told you the plane would crash, the plane has now finally crashed and we don't get a do over here unfortunately.

This outcome has been entirely predictable. But as long a no bad outcome was to be had yet, the five alarm fire was addressed in a less than emergent manner. I am disappointed that our approach has led to my patient now being blind.

Paul

# **APPENDIX, DOCUMENT #28**

**From:** Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>

**Sent:** Saturday, September 28, 2024 11:59 AM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Ragosta, Michael \*HS <[MR8B@uvahealth.org](mailto:MR8B@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>; Kramer, Christopher M \*HS (Cardiology) <[CMK2N@uvahealth.org](mailto:CMK2N@uvahealth.org)>; Rosner, Mitchell \*HS <[MHR9R@uvahealth.org](mailto:MHR9R@uvahealth.org)>; Hoke, Tracey R \*HS <[TRH9K@uvahealth.org](mailto:TRH9K@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Subject:** Re: M&m Wednesday

I agree. Timely presentation is important. I'm not sure why we would wait on this.

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**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>

**Sent:** Saturday, September 28, 2024 11:43:54 AM

**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Ragosta, Michael \*HS <[MR8B@uvahealth.org](mailto:MR8B@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>; Kramer, Christopher M \*HS (Cardiology) <[CMK2N@uvahealth.org](mailto:CMK2N@uvahealth.org)>; Rosner, Mitchell \*HS <[MHR9R@uvahealth.org](mailto:MHR9R@uvahealth.org)>; Hoke, Tracey R \*HS <[TRH9K@uvahealth.org](mailto:TRH9K@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Subject:** Re: M&m Wednesday

Allan,

I feel very strongly this case should be presented this Wednesday at the combined M&M as do Drs. Taylor and Saxon. All three of us were in the cath lab that day.

Thanks for your support,

Mark

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---

**From:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>

**Sent:** Saturday, September 28, 2024 11:39:00 AM

**To:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Ragosta, Michael \*HS <[MR8B@uvahealth.org](mailto:MR8B@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>; Kramer, Christopher M \*HS (Cardiology) <[CMK2N@uvahealth.org](mailto:CMK2N@uvahealth.org)>; Rosner, Mitchell \*HS <[MHR9R@uvahealth.org](mailto:MHR9R@uvahealth.org)>; Hoke, Tracey R \*HS <[TRH9K@uvahealth.org](mailto:TRH9K@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Subject:** RE: M&m Wednesday

I am going through the chart to understand the mortality and don't even see an operative/procedure note after opening the chest.

I just talked to Dr. Ragosta and including Dr. Preventza since this is their original case where the complication occurred. It seems from Dr. Ragosta that this is a rare and delayed event from wire complication.

As I said previously, this case will be presented as it has educational value to our trainees but I believe the RCA investigation should occur first to gather all the details.

The RCA starts on Monday and we will present this at our Department M&M after investigation is completed.

The next TCV multi-specialty M&M is Nov 6<sup>th</sup> and can present at that time.

I am including Drs. Kramer and Rosner from cardiology and Medicine to understand the urgency in presenting at our Department of Surgery M&M prior to detailed investigation through RCA from the medical center. If I am missing something please let me know. Happy to discuss more.

Thanks.

Allan

**From:** Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>

**Sent:** Saturday, September 28, 2024 11:23 AM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Ragosta, Michael \*HS <[MR8B@uvahealth.org](mailto:MR8B@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>

**Subject:** RE: M&m Wednesday

Hi Mark,

I am happy to be there and I agree it should be discussed.

Angela

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>

**Sent:** Saturday, September 28, 2024 10:25 AM

**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Taylor, Angela M. \*HS (MD-INMD CV Medicine) <[AMT6B@uvahealth.org](mailto:AMT6B@uvahealth.org)>; Ragosta, Michael \*HS <[MR8B@uvahealth.org](mailto:MR8B@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>

**Subject:** Re: M&m Wednesday

Allan,

I feel strongly it should be presented and I will have the cardiologist involved in attendance. They are included on this email.

Thank for your support,

Mark

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**From:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>  
**Sent:** Saturday, September 28, 2024 10:01:40 AM  
**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>  
**Subject:** Re: M&m Wednesday

Mark

Happy to discuss at one of our M&Ms but it seems this case should be presented when cardiology is present at next TCV multi specialty M&M.

The medical center is doing RCA for this patient on Monday so we will get more information. Thanks.  
Allan

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---

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>  
**Sent:** Saturday, September 28, 2024 9:39:43 AM  
**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Zaydfudim, Victor M \*HS <[VZ8H@uvahealth.org](mailto:VZ8H@uvahealth.org)>  
**Subject:** M&m Wednesday

I would like to present the case of [REDACTED] as the first case for m&m Wednesday. I feel strongly that it should be presented and I am sorry for the late notice.

Thanks,  
Mark

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**"This email originated outside the organization. Do not click any links or attachments unless you have confirmed the legitimacy of the message."**

**From:** Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Sent:** Monday, September 30, 2024 2:47 PM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>

**Subject:** Re: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Understand, unfortunately I am unable to attend.

Thanks

Reid B. Adams, M.D., F.A.C.S  
Claude A. Jessup Professor of Surgery

Chief Medical Officer  
UVA Health

---

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>

**Sent:** Monday, September 30, 2024 2:40:00 PM

**To:** Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>; Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>

**Subject:** Re: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Reid,

The request was just to attend the m&m. I am not very involved with the TAVR program, but I think the case should be presented this week (as do all the physicians who were in the room) to know how we as a cardiovascular center and surgery department should handle these cases/situations.

Thanks,  
Mark

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**From:** Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Sent:** Monday, September 30, 2024 1:05 PM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>

**Subject:** RE: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Mark, thank you for the invite. I am committed this Wednesday morning and it is an obligation I am unable to change. I am meeting with an external group coming into town. I assume this M&M

request is related to Friday's case. If I can get a little lead time, I can try to change my commitments if it can be done on an alternate Wednesday.

In reading through the email chain and not having the details to be understand the discussion or concerns, is the request to meet with me about the TAVR program specifically or to attend the M&M?

Thanks,

Reid

*Reid B. Adams, M.D., F.A.C.S.*

Claude A. Jessup Professor  
Department of Surgery

Chief Medical Officer  
UVA Health, University of Virginia Medical Center

Phone 434-243-4360

Email [rba3b@uvahealth.org](mailto:rba3b@uvahealth.org)

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>

**Sent:** Monday, September 30, 2024 12:19 PM

**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>

**Subject:** Re: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Dr. Adams,

Can you please join us for general surgery/tcv m&m Wednesday October 2ns at 7am.

Thanks,

Mark

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**From:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>

**Sent:** Monday, September 30, 2024 10:28:03 AM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Preventza, Ourania \*HS <[XWJ2ME@uvahealth.org](mailto:XWJ2ME@uvahealth.org)>

**Subject:** RE: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Mark

These are better discussed in person to understand all perspectives.

You specifically said you were concerned enough about patient safety that when I asked if we should put a hold on TAVR program, you said yes. That is very concerning and your only answer was that you and Dr. Preventza disagreed on consent. That do me does not warrant shutting down a program.

At this point, I recommend you discuss patient safety with Dr. Adams and I will discuss your other interactions with me.

Allan

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>

**Sent:** Monday, September 30, 2024 10:03 AM

**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yount, Kenan W \*HS <[KWY5D@uvahealth.org](mailto:KWY5D@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>; Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>

**Subject:** Re: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Allan,

I have had 2 separate phone discussions with you about the urgency in presenting this at m&m. There is also an extensive email chain from this weekend, where everyone physician in the room has asked for it to be presented. I invited Dr. Saxon and Dr. Yount, the heads of the TAVR program, Dr. Yarboro who was involved with the case, Dr. Gangemi my boss, and Dr. Tracci the head of Csec to attend this meeting as we'll, because you seem unsatisfied with the answers I have provided you.

I will try to attend at 4:30 if my case is finished.

Thanks for your support,  
Mark

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---

**From:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>

**Sent:** Monday, September 30, 2024 9:54:36 AM

**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>; Adams, Reid B \*HS <[RBA3B@uvahealth.org](mailto:RBA3B@uvahealth.org)>

**Subject:** FW: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Mark

I was very clear as to what the agenda was when I emailed you this weekend after our phone call:

“Mark

I would like to meet Monday with you to understand your concerns of urgent patient safety from the TAVR case that you stated during our phone conversation today. I am free in morning before clinic in afternoon. Otherwise we can meet late afternoon. Thanks.

Allan”

If you do not want to discuss with me despite your multiple emails to me to present this case in urgent manner, please plan to meet with Dr. Adams as any issues with patient safety is a priority.

However, I just got a BeSafe this morning regarding your interaction with Dr. Preventza in her office Friday afternoon. I will need to meet you to hear your perspective on this as well.

Thanks.  
Allan

**From:** Lira, Summer L \*HS <[SB9UC@uvahealth.org](mailto:SB9UC@uvahealth.org)>  
**Sent:** Monday, September 30, 2024 9:44 AM  
**To:** Tsung, Allan \*HS <[CRF9AA@uvahealth.org](mailto:CRF9AA@uvahealth.org)>  
**Subject:** FW: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

**From:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>  
**Sent:** Monday, September 30, 2024 9:35 AM  
**To:** Lira, Summer L \*HS <[SB9UC@uvahealth.org](mailto:SB9UC@uvahealth.org)>  
**Cc:** Gangemi, James J \*HS <[JJG5D@uvahealth.org](mailto:JJG5D@uvahealth.org)>; Tracci, Margaret Clarke \*HS <[MSC7S@uvahealth.org](mailto:MSC7S@uvahealth.org)>; Yarboro, Leora T \*HS <[LJT9R@uvahealth.org](mailto:LJT9R@uvahealth.org)>; Saxon, John T \*HS <[CPT6VH@uvahealth.org](mailto:CPT6VH@uvahealth.org)>  
**Subject:** RE: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

I wanted to invite others as he invited Janet Heinzman. Is that not appropriate? Also there is no agenda for this meeting.

Thanks,  
Mark

**From:** Lira, Summer L \*HS <[SB9UC@uvahealth.org](mailto:SB9UC@uvahealth.org)>  
**Sent:** Monday, September 30, 2024 9:31 AM  
**To:** Roeser, Mark E \*HS <[MR8BE@uvahealth.org](mailto:MR8BE@uvahealth.org)>  
**Subject:** RE: Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1

Hi Dr. Roeser,  
Dr, Tsung wanted to meet with you 1:1 may I ask why you extended the invite to other faculty?

Thanks,  
Summer

-----Original Appointment-----

**From:** Microsoft Outlook <[MicrosoftExchange329e71ec88ae4615bbc36ab6ce41109e@uvahealth.org](mailto:MicrosoftExchange329e71ec88ae4615bbc36ab6ce41109e@uvahealth.org)>  
**On Behalf Of** Roeser, Mark E \*HS  
**Sent:** Monday, September 30, 2024 9:10 AM  
**To:** Lira, Summer L \*HS  
**Subject:** Meeting Forward Notification: Dr. Tsung/Dr. Roeser 1:1  
**When:** Tuesday, October 1, 2024 4:30 PM-5:00 PM (UTC-05:00) Eastern Time (US & Canada).  
**Where:** Dr. Tsung's office West Complex Room 4536

## Your meeting was forwarded

[Roeser, Mark E \\*HS](#) has forwarded your meeting request to additional recipients.

### Meeting

Dr. Tsung/Dr. Roeser 1:1

### Meeting Time

Tuesday, October 1, 2024 4:30 PM-5:00 PM.

### Recipients

[Gangemi, James J \\*HS](#)

[Yount, Kenan W \\*HS](#)

[Saxon, John T \\*HS](#)

[Tracci, Margaret Clarke \\*HS](#)

[Yarboro, Leora T \\*HS](#)

All times listed are in the following time zone: (UTC-05:00) Eastern Time (US & Canada)

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Sent by Microsoft Exchange Online

**"This email originated outside the organization. Do not click any links or attachments unless you have confirmed the legitimacy of the message."**

# **APPENDIX, DOCUMENT #29**



*Clinical Staff Office*  
*University of Virginia Medical Center*

**Confidential and Privileged**  
**Privileged Under Virginia Code § 8.01-581.17**

**Margaret C. Tracci, MD, JD**  
Professor of Surgery  
President, Clinical Staff  
Chair, Clinical Staff Executive  
Committee

**Michael Ragosta, MD**  
Professor of Internal Medicine  
Vice President, Clinical Staff  
Chair, Credentials Committee

**Diane E. Pappas, MD, JD**  
Professor of Pediatrics  
Chair, Professional Practice  
Evaluation Subcommittee

**Peggy P. McNaull, MD**  
Professor of Anesthesiology  
Chair, Peer Support & Triage  
Subcommittee

**Matthew P. Robertson, ACNP**  
Co-Chair, Advanced Practice  
Providers  
Peer Evaluation Subcommittee

**Kathryn E. Morgan, AC-PNP**  
Co-Chair, Advanced Practice  
Providers  
Peer Evaluation Subcommittee

October 21, 2024

Mark E. Roeser, MD  
Via e-mail: mr8be@uvahealth.org  
Associate Professor of Surgery  
2665 Stowe Ct.  
Charlottesville, VA 22908

Dear Dr. Roeser,

Thank you for attending the Credentials Committee on Friday, October 11, 2024 to provide additional information on the mortality event that occurred on September 27, 2024 involving an 83-year-old patient admitted on 9/26/2024 for a planned transcatheter aortic valve replacement (TAVR) procedure where the patient initially did well. The next morning, the patient developed tamponade and an emergency pericardiocentesis was done but she continued to bleed with ongoing tamponade and required emergency sternotomy to relieve tamponade and attempt repair of the late onset LV perforation responsible for tamponade. Clinical Care and Mortality review was conducted following standard departmental/quality M&M Process.

The focus of the Credentials Committee discussion was to review the Be Safe Events filed on you (Be Safe 224982 and Be Safe 224982) alleging unprofessional conduct reporting intimidation, bullying, feeling disrespected and fearful of one's safety occurring at a meeting where you attempted to meet with your Division Chief to discuss the mortality event described above and concerns regarding the emergent response and care of the patient.

After review and committee deliberation, the Credentials Committee found no evidence that you violated policy 262 and recommended that no action be taken on your clinical privileges.

The Credentials Committee recognizes this event to be a very complex case and stressful for the entire clinical care team. The Credentials Committee will continue to work with Department and Health System Leadership to identify and support our clinicians in navigating challenges that may hinder the ability to be successful in meeting the Missions, Values, and Goals of UVA Health.

Best regards,

Michael Ragosta, MD  
Vice President of the Clinical Staff  
Chair of the Credentials Committee.

# **APPENDIX, DOCUMENT #30**

 Outlook

---

**FW:** [REDACTED]

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**From** Yates, Paul A \*HS <PAY2X@uvahealth.org>  
**Date** Wed 8/24/2022 7:18 PM  
**To** Warburton, Karen \*HS <KMW2G@uvahealth.org>

**From:** Yates, Paul A \*HS  
**Sent:** Wednesday, March 31, 2021 8:58 PM  
**To:** White, Skip \*HS <ROW9C@hscmail.mcc.virginia.edu>; Gehle, Bruce \*HS <BDG5QR@hscmail.mcc.virginia.edu>  
**Subject:** Fwd: [REDACTED]

FYI another one

Sent from my iPhone

Begin forwarded message:

**From:** "Kirzhner, Maria \*HS" <MK5RK@hscmail.mcc.virginia.edu>  
**Date:** March 31, 2021 at 5:59:45 PM EDT  
**To:** "Brooking, Susan A \*HS" <SAB7YD@hscmail.mcc.virginia.edu>, "Pate, Kim \*HS" <KP2ZP@hscmail.mcc.virginia.edu>, "Fellows, Katherine H \*HS" <KF6W@hscmail.mcc.virginia.edu>  
**Cc:** CL EYE FACULTY <CLEYEFACULTY@hscmail.mcc.virginia.edu>  
**Subject:** RE: [REDACTED]

Thank you Susan for having them come in today. They had a blinding infection and are now admitted to the hospital.

Another example of serious issues getting lost in the ether...

I would like for the team to figure out why I did not hear about this on Tuesday, as this could have been treated earlier and prevented from getting so out of hand. This man can go blind from orbital cellulitis.

mk

---

**From:** Brooking, Susan A \*HS  
**Sent:** Wednesday, March 31, 2021 8:45 AM  
**To:** Kirzhner, Maria \*HS <MK5RK@hscmail.mcc.virginia.edu>  
**Subject:** [REDACTED]

Patient came in on Monday to see Dr. Duphraise. Patient called in yesterday around 3:30 ish. Said they sent pictures of his eye to OPHBLUE email. which was never received. I am not sure why this was done and why this was not sent to oncall if he was still having problems. Wife is panicked.

Patient's eye is swollen red and he can't open it. I looked at your schedule today and told them to come in to see you at 11 am (post op slot) He did not want to see the oncall again.

# **APPENDIX, DOCUMENT #31**



---

FW: [REDACTED]

---

From Yates, Paul A \*HS <PAY2X@uvahealth.org>  
Date Wed 8/24/2022 6:45 PM  
To Warburton, Karen \*HS <KMW2G@uvahealth.org>

-----Original Message-----

From: Yates, Paul A \*HS  
Sent: Saturday, May 7, 2022 2:14 PM  
To: hwu2db@virginia.edu  
Cc: Olsakovsky, Leslie \*HS <LAO5Q@hscmail.mcc.virginia.edu>; Cusick, Michael \*HS <MC9CR@hscmail.mcc.virginia.edu>  
Subject: [REDACTED]

John,

Yesterday I had a 50 patient clinic (typical for a retina specialist) clinic. By noon I was 2 1/2 hours behind. Yet I finished my clinic at 4:30. The difference for the lengthy morning delays was that all morning I had no patient coordinator and no injection medical assistant. I also only had two work up technicians for the mornings 30 patients. So my scribe (who I directly cover salary for) and I did both these vacant jobs ourselves. One faculty member was out with Covid for in the afternoon so I had more help to finish early.

I would love to tell you this is atypical. Leslie and Michael can attest it is unfortunately not. I would love to tell you it is a pandemic blip, but it is not, this has been a serial problem for years. It is what resulted in such a frosty relationship with Kim Daniels and Rachel Boston who managed and staffed this clinic for several years.

I have finally been forced out of exhaustion for my patients, our staff, and myself to reduce my clinics to sub-normal 40 patient load. I made this change even after one of our retina specialists Dr Shildkrot abruptly resigned last month. Our load is greater than at any time recently. I have to turn away patients left and right.

Our retina colleagues in town typically have 5 technicians for their 50 patient clinics. We typically have two and if lucky maybe 3. Often our Northridge clinic manager is doing work up herself for me instead of managing the clinic, otherwise we'd have one work up technician. Several of our technicians left, to ironically go work for our retina colleagues in town. We have had substantial staff turnover in the last few years, to the point I just learn our new technicians names and then they leave.

I don't want this email to be about my patients and myself specifically. This is a clinic wide issue. Dr Olsakovsky had one technician to work up 20 patients this week. I expect it even ventures beyond ophthalmology.

I also don't want it to be about criticism of yourself, Renee Viette, and Stephanie Dixon. I have high confidence in all of you that you want us to be better. Renee has direct experience as manager of our clinics in years past and I know she is fantastic and cares a lot. Stephanie had led our OMS clinic as lead technician for years and does an amazing job. And while I don't know you well, I have no doubt if Dr Kent hired you for this position it was due to great past performance.

That said, the trouble is that despite a high performing administrative staff, we aren't better. We are very clearly worse. Please forgive me, but I have every few years someone new show up and listen to our problems with staffing and clinical efficiency and promise it will be different. But it never is. This suggests to me less personnel issues, and less administrative performance, than an endemic structure to how we run our operation that is incredibly resistant to change. It also suggests a focus less on what our on the ground staffing and morale is and what our patient experience is, than on other more acute issues that arise in clinical operations each day. And let's not forget the 100 lb gorilla JCHAO. Again I don't blame any of you for that. Your jobs were structured to prioritize this above over the issues I have described.

I asked my outside colleagues how they can possibly afford 5 technicians when we can afford only 2. Their answer was quite revealing. They stated each technician cost them \$250 a day. They further stated that if each technician allowed them to see 1 more patient in a day they made up the difference right there. They further added that with 5 technicians there was always someone to handle whatever issue came up, their technician burnout was significantly lower, and their patients and physician were happier each day. With the technical staff number and morale I have seen, I am sorry to say that this approach is not reflected in our staffing currently (or honestly for many years). I know Renee and Stephanie are trying to get us to par, but we remain way far away from that goal.

At this point short of any demonstrable change in staffing I have simply given up. I am capped at 40 with long waits to see me. I may have to go even lower to keep everyone happy. I have limited what urgent patients I can see because there is simply put no space for them (and no available OR block time to operate on them even if I could see them - but that's another issue unto itself.)

I don't send this to you expecting you to do anything about it. I don't even ask you to respond. There are probably way too many clinical fires that need fought at this time. Nevertheless I wanted to give you personal feedback of how this is being fought on the ground every day and how I have needed to finally raise a white flag.

If I see change I will open my clinics back up to greater patient loads to meet demand. But until then, to protect patients, staff, and myself I am stuck where I am stuck. Even at this reduced load it remains a struggle as the reduced staffing still often fails to meet the clinical demands.

To the degree I can help support your, Renee's and Stephanie's efforts I am happy to do so. Good luck and I hope you will be able to meaningfully change the structure of our clinics to focus on patient experience which I know is why all of us do what we do each day.

Paul

Sent from my iPhone

# **APPENDIX, DOCUMENT #32**



Outlook

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**FW: Last comment on our approach to PFA**

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From Yates, Paul A \*HS <PAY2X@uvahealth.org>

Date Wed 8/24/2022 7:15 PM

To Warburton, Karen \*HS <KMW2G@uvahealth.org>

Karen,

This was the original email (oddly almost a year to the day before the next one) involving my monocular patient who called in with new vision changes and was told I have no appointments for 2 months and went legally blind because of it.

Again I'm not proud of it.

Karen I take a pretty simple approach with most people I come across. It is admittedly blunt. If you make a mistake, even a grievous one ( for instance my administrative assistant forgot to pick up our after hours log and therefore missed scheduling a patient for follow-up who went blind), I will not be happy about it, but lesson learned, please see what corrective actions are needed and prevent it from happening again. If it happens a second time, then the mistake was not serious enough for you to pay enough attention to solve the problem.

We had no less than 5 patients whose retinal detachments or corneal ulcers were mismanaged by PFA but we caught the error just in time and rescued the eye. We warned our new system that unless rapid immediate corrective actions were taken that a patient was going to go blind. No corrective actions were taken. We had lots of strategy planning over this instead, including an infamous one where Katie, head of all PFA, opened up a blank power point and asked us about our idea which she then wrote down. A patient went blind. My patient. I have had to deal with the outcome of this over the last year and the profound effect it has had on his quality of life.

I know stuff happens, mistakes are made, but this was an entirely preventable mistake, a mistake that was foretold, and the only one who took any damage from this incident were my patient and myself.

More emails to follow.

Paul

-----Original Message-----

From: Yates, Paul A \*HS

Sent: Friday, March 26, 2021 8:01 PM

To: Fellows, Katherine H \*HS <KF6W@hscmail.mcc.virginia.edu>; Pate, Kim \*HS <KP2ZP@hscmail.mcc.virginia.edu>

Subject: Last comment on our approach to PFA

Kim and Katie,

I have stated on no less than 5 occasions, going back to early January, that ANY change in patient vision or symptomatic worsening of eye symptoms should be met with an immediately referral to an eye care provider. It was a view backed up by multiple staff members and repeated multiple times. It was a lesson even my 11 year old daughter could follow. You didn't need a flowchart, you didn't need a question and answer session with the patient, you didn't need to know which service they belonged to, you didn't need to know when their next appointment was, you didn't need a powerpoint, you didn't need a zoom call, you didnt need a weekly planning session, you didn't need a 2 week training session of your PFA associates. One simple straightforward rule that we asked you to implement immediately. For reasons I will never fathom, this was ignored. I guess you both knew better than me. Sorry, but whatever transpires next with our patients is entirely on both of you. This is what not doing your jobs looks like. And yes I won't forget any of this soon. Please feel free to forward this email to whom ever you wish. I am done with being even remotely patient with this process anymore.

Paul

Sent from my iPhone

ALERT FEATURED TOP STORY

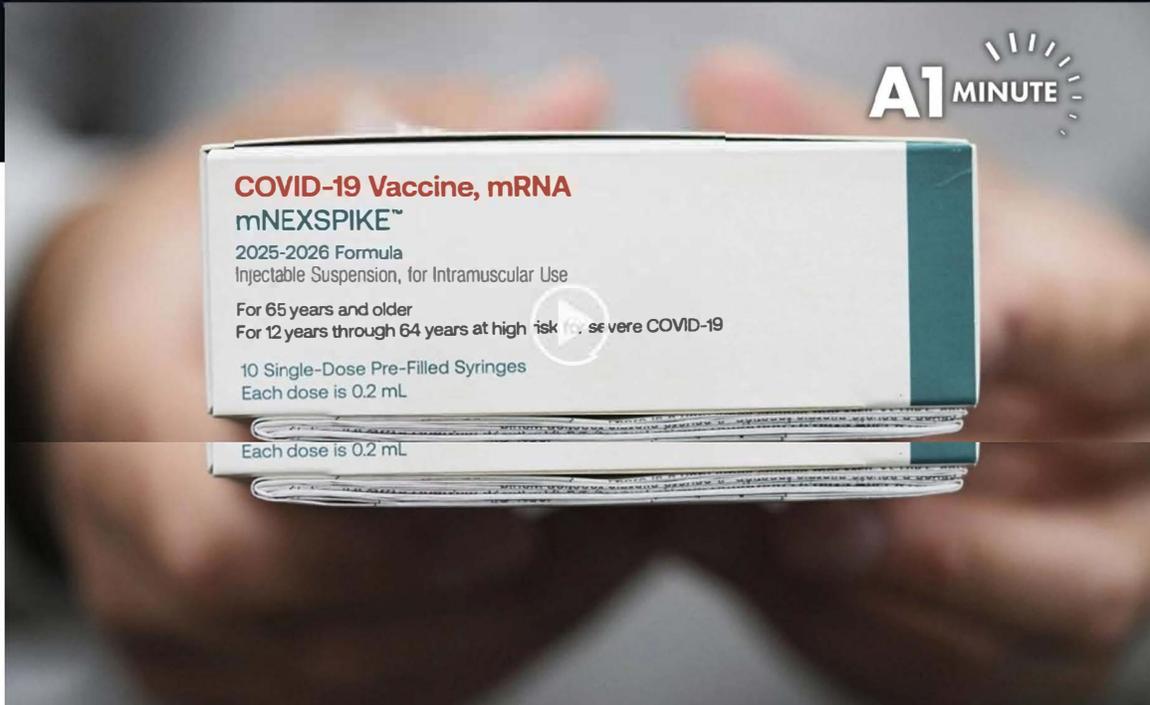
COURT



# Lawsuit: Kent led 'hostile takeover' of UVa Health

Dr. Craig Kent and the top brass he hired at UVa Health have been named in a lawsuit demanding compensation for the overbilling, retaliation and deaths it says occurred on their watch.

David Velazquez Oct 19, 2025 1



Week in Virginia



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**E**ight months after he submitted his resignation, Dr. Craig Kent faces a lawsuit that alleges he orchestrated a hostile takeover of the University of Virginia Health System and proceeded to institute illegal practices that led to worse outcomes, including the deaths of two patients, and a culture of fear, intimidation and retaliation.



UVA  
**Mitch Rosner named UVa Health CEO**  
David Velazquez

The 100-plus-page suit, filed Oct. 3 in the U.S. District Court of the Western District of Virginia by the widows of two dead UVa patients and a handful of doctors, alleges the “Kent Enterprise” committed fraud, illegally retaliated against employees who challenged their CEO’s authority and violated the Racketeering and Corrupt Organizations, or RICO, Act.

"This case arises out of a hostile takeover of a revered medical system by a cadre of individuals determined to maximize revenues and rankings, thereby inflating their own career prospects and financial gain, through concerted, repeated, and consistent illegal acts," according to the plaintiffs.

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- 4 [Greene authorities searching for man reported missing after car crash](#)



University of Virginia Medical Center in Charlottesville is seen on Friday, Sept. 20, 2024.

CAL CARY, THE DAILY PROGRESS

Their suit was filed roughly 13 months after 128 physicians and faculty members signed a letter of no confidence in UVA Health leadership, prompting an investigation that led to Kent's resignation, followed by the resignation of multiple other high-ranking UVA Health officials.

Plaintiffs, represented by the Charlottesville-based firm of MichieHamlett and New Orleans-based Jones Swanson Huddell, requests compensation, but as a civil suit theirs cannot and does not seek any relief for any crimes committed.

"What we can do under the law is bring a RICO action when there is an enterprise established to engage in criminal acts that damage and hurt people; and that's what we've alleged here," attorney Gladstone Jones of Jones Swanson Huddell told the Daily Progress.

That said, the suit is the first time a public document has explicitly said UVA Health is the target of a federal investigation.

"The United States Department of Justice launched an investigation into unlawful billing practices and regulatory misconduct by UVA Affiliates and the Kent Enterprise," the suit reads.

## EXITS AND INVESTIGATIONS

Many of the named defendants in the suit are no longer at UVa, with most of them resigning within a five-month span between February and July.

An internal UVa memo in July revealed Wendy Horton, CEO of UVa's flagship medical center in Charlottesville, would be leaving for the University of California, San Francisco, health system. The next month, Dr. Melina Kibbe, dean of the UVa School of Medicine, announced she would be leaving for the University of Texas Health Science Center at Houston.

Kent's resignation came earlier, in February, after UVa's governing Board of Visitors reviewed a report prepared by the Washington-based law firm of Williams & Connolly, which had been tasked with investigating the claims of illegal and unethical wrongdoing in the health system. Physicians and faculty members said Kent and his top brass lined their pockets while hospitals remained short-staffed, tampered with billing and patient records, disregarded policies, tenure and ethics, and threatened those who spoke out against them.

The Board of Visitors meeting was held behind closed doors and the report's findings have never been made available to the public.

The claims made in the civil suit filed earlier this month mirror those Williams & Connolly investigated,

according to MichieHamlett attorney Les Bowers. Bowers said plaintiffs have waited months for the health system to take responsibility for the illegal and unethical practices of the Kent administration.

"We interfaced repeatedly with university counsel's office and UPG [the UVa Physicians Group], and in multiple conversations, we gave them extensions on extensions to try to avoid to file. I saw them multiple times," he told The Daily Progress. "No one wanted to accept responsibility or even take the claim seriously, and so here we are."

Jones said Kent, Horton, Kibbe and others named in the lawsuit "were directly involved in the development of the strategy that included these illegal acts and caused these damages. And that's why they were named and others were not."

UVa Health is keeping quiet.

Health system spokesman Eric Swensen told The Daily Progress "the University does not generally comment on pending litigation."

Kibbe, no longer with university, was less tight-lipped when she spoke with the Houston Chronicle about the matter.

Kibbe told the newspaper it is "unfortunate that these unfounded and baseless allegations continue to be brought forth" and she is eager for "the truth to prevail through the judicial system as there is no legal basis for this lawsuit."

## The 'Kent Enterprise'

Plaintiffs allege that Kent began constructing his criminal enterprise shortly after his hiring in February 2020, hiring Horton a month later "without meaningful faculty input or a competitive search process."

Prior to their arrival in Charlottesville, Kent and Horton had overlapping stints at Ohio State University and the University of Wisconsin.



Horton

At Ohio State University, where Kent was dean of the College of Medicine and Horton was chief administrative officer of the Wexner Medical Center, Kent was the target of another letter of no confidence, claiming he and others lacked respect for the academic mission of the university and its health system.

While Kibbe and Kent did not overlap at any university health system (at least not according to their public resumes), it was widely reported that she was handpicked for the job leading the School of Medicine at UVa the year after Kent took the helm.

During Kent's five-year tenure at UVa, roughly 550 faculty members and 16 of the 21 clinical department chairs at the School of Medicine were replaced or hired.

"The Kent Enterprise engaged in what amounted to a hostile takeover of UVA's medical institutions. They swept aside long-serving leaders, silenced dissenters, and installed loyalists in key roles to clear the way for their profit-driven scheme," the suit says.

Almost all of the new hires "were selected outside of traditional governance protocols and long-established policies and procedures," according to the suit.

The suit names two hires in particular, Dr. Ourania Preventza and Dr. Kim De La Cruz, who it says not only helped further Kent's takeover but whose incompetence led to the deaths of two patients.

The suit says De La Cruz was hired despite knowledge of his lack of surgical skill or administrative experience, as well as his dangerous incompetence, because he would further the Kent Enterprise.

According to the plaintiffs, De La Cruz was hired despite surgical skill or administrative experience.



Dr. Craig Kent, CEO of the University of Virginia Health System, speaks during a UVA Health System Board meeting at Boar's Head Resort in Albemarle County on Thursday, Sept. 12, 2024.

CAL CARY photos, THE DAILY PROGRESS

The chief of cardiac surgery at Brigham and Women's Hospital in Massachusetts, where De La Cruz was on probation and could not perform surgeries independently, is quoted in the suit saying that if De La Cruz "had not left Brigham and Women's Hospital, he would have been fired."

According to the suit, De La Cruz was required to have a proctor during certain

surgeries at UVa, but during the one that led to the death of a patient, the proctor

surgeries at UVa, but during the one that led to the death of a patient, the doctor selected to accompany De La Cruz was one of the newest members of the Cardiothoracic Department and was not in the operating room the entire surgery as required by UVa Health's own policies.

"In addition, De La Cruz ... engaged in fraudulent billing practices, including upcoding surgical risk levels to inflate reimbursement rates, and fraudulent charting, including falsification of medical records to avoid malpractice liability," the suit says.

The suit alleges that De La Cruz, before the operation that proved fatal, calculated that the risk factor of death was about 3%, but after the operation, the risk score was changed to more than 20%.

The upped risk factor "triggered a higher, complexity-driven Medicare reimbursement for the procedure" and "sought to minimize any potential malpractice liability."

Claims of fraudulent billing were not uncommon during Kent's time at UVa. The suit says Kent's Department of Surgery shifted "physician compensation exclusively to productivity metrics measured by Relative Value Units (RVUs), which incentivize volume and billing intensity over patient outcomes."

The shift "created strong incentives for billing abuse," the suit says.

As The Daily Progress previously reported after interviewing multiple current and former UVa Health officials and employees, there was "tremendous pressure" from senior leadership for physicians to charge patients more for treatment.

Michael Cannon, director of health policy studies at the Cato Institute think tank in Washington, told The Daily Progress last October that the federal Medicare insurance program in particular incentivizes hospital administrators to "encourage aggressive coding" practices.

"Upcoding in Medicare is rampant and notorious," said Cannon, who likened the Centers for Medicare & Medicaid Services to an ATM that rarely scrutinizes the bills sent its way and simply hands over the cash to health systems.

Preventza "often extolled the use of fraudulent double-billing and advocated that the UVA Affiliates adopt the process," according to the suit.

Double-billing is a process in which a hospital bills for two primary surgeons when two aren't needed.

Just last year, Preventza's previous employer, Baylor St. Luke's Medical Center in Houston, agreed to pay a \$15 million settlement after it was accused of double-billing patients.

At UVa, the suit says, Preventza and De La Cruz submitted claims for surgeries not performed jointly or without appropriate supervision and attempted to force others to do so too

"Residents were instructed to misrepresent the structure of procedures and Preventza ordered them to perform procedures they had not yet been taught. Credentialing, privileging, and documentation related to the same were altered and falsified to increase billing," the suit reads.

## Retaliation

The suit alleges that a handful of UVa doctors who stood up to leadership were silenced, demoted and disciplined.

One of the plaintiffs, Dr. Kenan Yount, claims he was told that Kent and Kibbe "were well-connected leaders and that crossing them could be 'not pleasant,'" when he attempted to bring up concerns about Preventza.

Following another attempt to bring up concerns, “two jobs were posted matching Dr. Yount’s and his partners’ job descriptions.”

Yount, who was director of the Structural Heart & Valve Center at the time, would later learn that a co-director had been hired at the center and that De La Cruz had been appointed to a position that he already held, according to the suit.

Yount ultimately left UVa Health in July.



Dr. Melina Kibbe, dean of the University of Virginia School of Medicine, attends a Health System Board meeting at Boar’s Head Resort in Albemarle County on Thursday, Sept. 12, 2024.

CAL CARY, THE DAILY PROGRESS

Another plaintiff, Dr. Mark Roeser, alleges that Preventza and De La Cruz filed reports against him, falsely accusing him of bullying and other inappropriate behavior.

“These reports were never meaningfully investigated; Dr. Roeser was never even questioned about them. They made their way to his permanent file, though,” the suit says.

The suit also alleges that surgeons who opposed leadership were threatened with having their clinical privileges revoked at five-on-one meetings. After those meetings, Kibbe is said to have delivered messages to the surgeons outlining “a blatant act of defiance, insubordination, disrespectful behavior, unprofessional behavior, and a lack of accountability to authority.” The letters were placed in physicians’ human resources files without following any typical procedures, according to the suit.

### **What’s next**

No date has been set for the suit to be heard in court, nor have all of the named defendants been served.

Attorneys for the plaintiffs said it is likely that the scope of the suit and the list of those implicated could grow.

Bowers said that “other people were involved, some of whom we have deliberately not named, some of whom we expect to learn more about once we get into the discovery process.”

He added that “people are coming out of the woodwork” to reach out to the attorneys with their claims or to share information regarding the case.

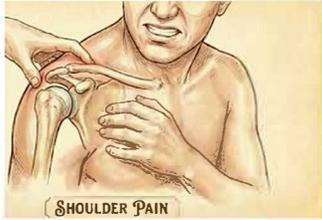
“An enormous amount of effort has been undertaken to understand exactly what happened at UVa, at the hospital, the medical school, and it’s just terrible, and it’s terrible for the people that brought this lawsuit, and it’s terrible for the community, and that is why the suit was filed,” Jones said.

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By David Velazquez

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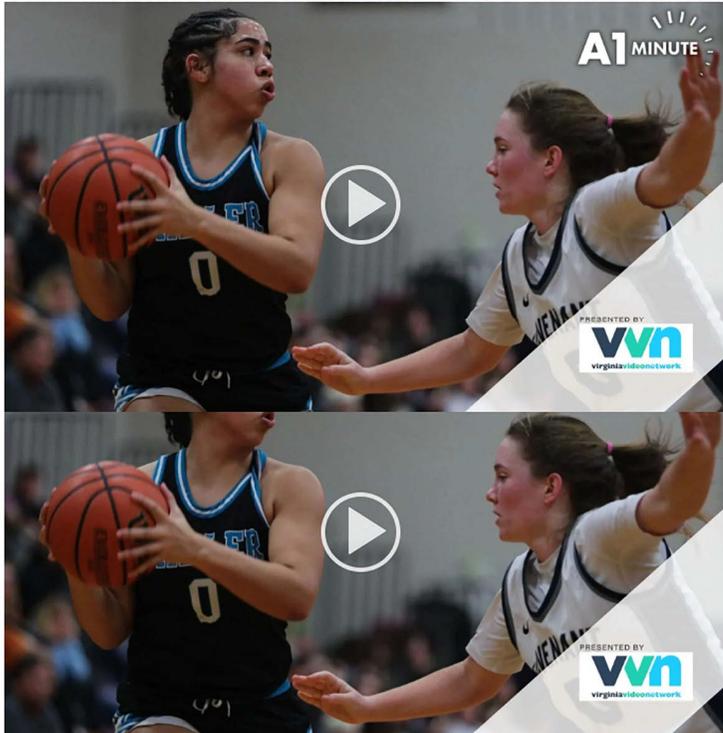
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News

# Doctors and widows sue UVA Health

RADIO IQ | By Sandy Hausman | Published November 11, 2025 at 12:13 PM EST



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Sanjay Suchak / UVA Communications

Former leaders of UVA Health, the physicians group, the Board of Visitors and the state are named in a federal lawsuit alleging they put patient safety at risk.

It's been about nine months since the former CEO at the University of Virginia Health Systems resigned. During his tenure, the medical center was accused of overbilling, putting patient safety at risk and creating a climate of fear among employees.

Now, some of them are suing Craig Kent, his team and UVA in federal court.

Lawyers for the plaintiffs are taking a surprising approach in the suit against Craig Kent, two administrators and three doctors he hired as well as the Board of Visitors, UVA's Physicians Group and the state. They claim Kent's team violated the Racketeering and Corrupt Organizations Act or RICO — determined to boost profits, UVA rankings and their personal financial prospects by committing fraud.

"Leadership had developed a strategy around increasing profits, increasing the national rankings, rolling back safety protocols designed to protect patients, retaliatory efforts against any professionals within the UVA medical system who stood up and complained," says Gladstone Jones, one of two lawyers who drafted the complaint.

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He says four doctors suffered serious professional harm as a result of Kent's approach to management.

"They were approached by this group of leaders and told they were being cited for unprofessional conduct. Letters were written by HR and put in their files. Promotions were beyond reach because of these acts. Titles were stripped. Expenses for conferences were taken away.

And attorney Lee Bowers says UVA inflated bills for surgery by claiming two senior doctors were needed in the operating room for cases that were not that complicated.

"It leads to increasing revenue when there's absolutely no need based on case complexity to have two attendings, but it's well-known that that is a way to scam Medicare."

He adds that other fraudulent tactics were used to cut costs and boost the bottom line.

"There are patients who had unnecessary procedures and people who went blind in the face of a year or more of warnings that this was going to happen if they continued to cut out the patient safety mechanisms in order to maximize financial goals."

And the suit alleges Kent and his colleagues hired doctors who were willing to go along with their strategy, even though they were not qualified to do surgeries.

"Anywhere that you could hire someone who would implement the strategy of up-coding and double-billing, that happened. Sixteen of 21 chairs were replaced, so we're talking about completely wiping out all of UVA's leadership in the space of four years so that Kent could install loyalists into those positions."

Joining the suit, two women whose husbands died after treatment at UVA.

The university said it does not comment on pending litigation, but Craig Kent told Charlottesville's daily newspaper that the lawsuit was "absurd, baseless, and motivated by greed." In a written statement, he said he and his team were focused on delivering exceptional and high-quality healthcare to Virginians and beyond.

The plaintiffs have not said how much they will ask in damages if they prevail in court. Legal experts say the university will likely try to have the case dismissed.

If it's unsuccessful, it might prefer to settle the matter rather than risk the release of records from an internal investigation that may have promoted Kent's resignation.



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**Sandy Hausman**

Sandy Hausman is Radio IQ's Charlottesville Bureau Chief

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