



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

Office of Healthcare Inspections

Report No. 14-04530-41

Healthcare Inspection

Emergency Department Concerns Central Alabama VA Health Care System Montgomery, Alabama

January 14, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of Emergency Department (ED) concerns at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery, AL. The purpose of this review was to assess the merit of the allegations and to follow up on survey responses from the 2014 OIG Combined Assessment Program (CAP) review.

We substantiated that CAVHCS was not meeting Veterans Health Administration's ED timeliness measures. Our review of 172 patients who received care in CAVHCS' Montgomery campus ED the week of September 1–7, 2014, reflected that ED waits were generally due to pending admission, undergoing treatment in the ED, or awaiting transfer to another facility for radiology/ultrasound services.

We did not substantiate that community based outpatient clinic providers refused to see walk-in patients and instead referred them to the ED, that ED patients' vital signs were not checked as required, that having just one physician on duty in the ED was routinely problematic, that patients were inappropriately referred to other facilities, or that social work staffing in the ED was inadequate.

We substantiated that, at times, staff were stretched to provide appropriate special observation to mental health patients in the ED. For example, we found that one licensed practical nurse provided special observation for three patients for almost 3 hours. While policy does not prohibit this, we question whether this staffing ratio was sufficient to assure patient and staff safety.

We were unable to fully assess seven allegations due to insufficient information and/or details. We did not identify conclusive evidence to either sustain or refute these allegations. Those allegations are included in Appendix A.

We recommended that the CAVHCS Director charter a system redesign team to focus on ED timeliness, revise the ED triage policy, and ensure adequate ED staffing to meet special observation needs.

Comments

The Interim Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 11–14 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of Emergency Department (ED) concerns at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery, AL. The purpose of this review was to assess the merit of the allegations and to follow up on survey responses from the 2014 OIG Combined Assessment Program (CAP) review.

Background

More than 15 years ago, the Montgomery VA medical center (VAMC) and the Tuskegee VAMC merged, forming the CAVHCS. This two-division health care system provides a broad range of inpatient and outpatient medical, surgical, mental health (MH), and long term care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) located in Dothan, Wiregrass, and Monroeville, AL, and in Columbus, GA. CAVHCS is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 134,000 in central and southeastern Alabama and western Georgia.

2014 OIG CAP Review

The OIG conducted a CAP review at CAVHCS the week of August 25, 2014. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. One objective of the CAP review is to conduct recurring evaluations of selected health care facility operations. As part of the CAP, we also surveyed all employees via an online employee assessment review (EAR). See *Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama*, Report No. 14-02079-10, November 25, 2014, for details.

Allegations

Two hundred twenty-nine CAVHCS employees responded to the EAR survey, many of whom identified quality, safety, and staffing concerns, and employees we interviewed noted similar concerns. This report addresses ED concerns including long delays, overcrowding, lack of appropriate staffing, quality of care deficits, and improper use of ED services.

Scope and Methodology

The period of this review was August 2014 through February 2015. We conducted site visits August 25–28, September 22–25, and November 3–5, 2014. We interviewed the acting CAVHCS Director, acting Chief of Staff, Associate Director, acting Chief of Ambulatory Care, acting Chief of MH, and the acting Chief of the ED; acute care, ED, and outpatient nurse managers; ED nurses and providers; Human Resource and Business Office managers; Quality Management staff and the Patient Safety Manager; a patient advocate; clinical and administrative staff from all four CBOCs; VISN

employees; and other staff knowledgeable about the issues.

To understand the scope of concerns and to assess the physical environments, we visited all four CBOCs and the Tuskegee and Montgomery campuses and conducted an unannounced inspection of the Montgomery ED. We interviewed more than 150 employees.

Prior to and during our site visits, we reviewed extensive system documentation, including Veterans Health Administration (VHA) and local policies, the Human Resources Restoration and Revitalization (HR³) Program site visit report, meeting minutes, Root Cause Analyses (RCAs), and other performance data. We also reviewed electronic health records (EHRs), staffing data, and relevant literature.

Many of the issues identified, primarily through the EAR survey, did not contain sufficient detail for us to fully evaluate them. We reviewed CAVHCS policies and data to determine whether the alleged conditions were possible and/or problematic. Those complaints are included in Appendix A on pages 9–10.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Emergency Department Concerns

CAVHCS' ED is located on the Montgomery campus and has seven medical beds and three MH beds.¹ At the time of our review, staffing included one physician² on duty each 12-hour shift and a nurse practitioner who worked an 8-hour shift Monday through Friday. Usually, four to six registered nurses (RNs) were assigned to the day and evening shifts, two RNs were assigned to the night shift, and one to two licensed practical nurses (LPNs) were assigned to each of the three shifts. The nurse manager stated that one nursing employee was on extended military leave and two other nursing employees were on extended administrative leave. Because CAVHCS was unable to hire for these three encumbered positions, the ED may not have been adequately staffed with nursing personnel at times.³ Physician and nursing support from the intensive care and medical/surgical units was available as needed.

Because we were not provided with specific details or case examples of deficient care in the ED, we reviewed the EHRs of all 172 patients seen in the ED during the week of September 1–7, 2014, to identify whether individual data or care patterns supported the claims.

Issue 1: Timeliness and Quality of ED Care

Allegation: The ED had long waits and was overcrowded.

We substantiated that CAVHCS was not meeting ED timeliness measures. VHA utilizes several measures to monitor ED performance, as follows:

Patients Left Without Being Seen. A facility is considered Fully Satisfactory if less than 3 percent of patients left without being seen and Exceptional if less than 1 percent did so.

For the 3-year period August 2011–August 2014, CAVHCS met the Fully Satisfactory threshold for 1 month. The facility did not reach Exceptional status. Of the 172 patients seen in the ED during the week of September 1–7, 2014, 7 (4 percent) left prior to being seen.

¹ The MH “beds” are actually lounge chairs.

² None of the ED physicians are trained in Emergency Medicine. While this training is not technically required, the acting ED Chief told us that CAVHCS is currently in the process of recruiting an emergency medicine-trained physician.

³ VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. This directive expired March 31, 2015 and has not yet been updated.

Patient Stays Over 6 Hours. A facility is considered Fully Satisfactory if less than 10 percent of patients waited less than 6 hours and Exceptional if less than 5 percent did so. For the period August 2011–August 2014, CAVHCS did not meet either threshold.

The patients who received care in the ED during the week of September 1–7, 2014, spent an average of 3 hours and 33 minutes in the ED; however, the time almost doubled for MH patients to 6 hours and 39 minutes. Overall, 68 patients were in the ED for greater than 4 hours. The reasons for extended stays in the ED included waiting on admission, undergoing treatment in the ED, and being sent to another facility for radiology/ultrasound services.

Overcrowding. While we did not observe this condition, the CAVHCS ED is small and may appear overcrowded during high-volume times.

Allegation: CBOC Primary Care providers would not see walk-in patients; instead, they would send those patients to the ED.

We did not substantiate the allegation; however, CBOC staff confirmed that, given the volume of patients and tight schedules, managing walk-in patients was an ongoing challenge. Columbus CBOC providers reported that, in general, they no longer had unscheduled appointments available during the day and tried to “fit” walk-in patients into the schedule. According to Columbus CBOC schedulers, some walk-in patients could wait several hours, if not all day, before being seen. This condition may explain why some patients may have either elected, or were encouraged, to go to the ED, as care might have been provided more promptly.

Five of the 172 patients we reviewed came to the ED from a Primary Care PC clinic, surgery clinic, the Tuskegee campus, or the Columbus CBOC for evaluation and treatment. These patients’ symptoms included swelling, abdominal pain, nausea, elevated blood pressure, elevated potassium level, and suicidal ideation.

Allegation: Patients were sent to other hospitals because CAVHCS did not provide the needed services.

While we confirmed that patients were sent to other hospitals because CAVHCS did not provide some services, we did not substantiate the implied inappropriateness of this. CAVHCS is not expected or required to provide all medical or ancillary services that a patient may need. For example, CAVHCS does not provide radiation oncology, neurosurgery, or some gastroenterology procedures. CAVHCS is required, however, to assure that services not provided in-house are readily available and accessible in the community or through another VA health care facility. While we acknowledge that sending patients to other facilities for services is less convenient for patients and providers, it is often the most appropriate avenue to assure patients receive quality health care.

Of the 172 patients whose EHRs we reviewed, 17 were admitted to the facility, 3 were admitted to another VA medical center, and 8 were admitted to local hospitals (primarily due to a lack of inpatient MH beds).

Allegation: ED patients' vital signs were not being checked as required.

We did not substantiate the allegation. We reviewed a random sample of 30 of the 172 EHRs and found that all contained timely documentation of initial vital sign completion. CAVHCS policy only addresses the requirement for reassessment, including vital signs, for patients designated as Emergency Severity Index (ESI)⁴ level 1; it does not address reassessment requirements for patients classified as ESI levels 2–5 who are the ones most likely to be waiting for care. All of the 172 cases were classified as ESI levels 2–5.

Allegation: ED triage notes are not entered into the EHR in a timely manner.

While we confirmed that triage notes can be delayed on occasion, we did not substantiate that this was a regular occurrence. VHA has no specific timeframe for when a triage note must be completed. The “first look” nurse or triage nurse initiates the triage note when the patient signs in to the ED, and the triage findings determine the urgency by which patients should be evaluated by an ED provider. For the 172 patients' EHRs we evaluated, the average time between when the patient “timed in” to the ED to when the triage note was signed was 39 minutes (range of 5 minutes to 3 hours).

Issue 2. ED Staffing

Allegation: The ED did not have enough staff to provide adequate special observation to MH patients.

We substantiated that, at times, ED staff were stretched to provide appropriate special observation to MH patients in the ED. VHA Directive 2010-008 provides guidance on the care and treatment of MH patients within the ED.⁵ The directive states that suicidal patients must be placed on 1:1 observation, defined as the constant observation of the patient by staff, until they are deemed no longer a risk. CAVHCS policy refers to this monitoring status as “special observation.” Observation rooms need to allow for patients to be observed for up to 23 hours and 59 minutes, contain a bed where a patient can sleep, and allow crisis stabilization and brief treatment to take place.

⁴ VHA Handbook 1101.05, *Emergency Medicine Handbook*, states that the Emergency Severity Index (ESI) is the sole triage tool used by VHA. The ESI is a way of categorizing patients arriving in an ED from the most severely ill (Level 1, which encompasses conditions like cardiac arrest in which immediate life-saving interventions are needed) to the least severely ill (Level 5 [non-urgent], where it is not anticipated that the patient will require labs or x-rays, but instead generally only topical or oral medications). This handbook expired May 30, 2015.

⁵ VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010. This directive expired February 28, 2015 and has not yet been updated.

At the time of our review, the Montgomery ED had a designated observation room with three lounge chairs that could accommodate three MH patients of the same gender.⁶ LPNs typically provided the special observation. Because VHA, CAVHCS policy, and The Joint Commission do not strictly require one employee to one patient, it would technically be acceptable for one or two LPNs to observe all of the special observation MH patients in the ED observation room simultaneously.

Of the 172 patients whose EHRs we reviewed, 23 were seen for MH-related issues and 19 were on close observation or 1:1 in the ED prior to admission or alternate discharge disposition. On 5 of the 7 days, two patients were on special observation for some overlapping period of time, and on 1 day, three⁷ patients were on special observation between about 2:30 p.m. and 5:20 p.m. One LPN provided the observation for all three patients and handed off the special observation to a second LPN at change of shift. While policy did not prohibit this staffing ratio, we question whether one LPN observing three special observation patients for almost 3 hours was sufficient to assure patient and staff safety.

Allegation: The ED had only one physician on duty.

While we confirmed that only one physician was on duty in the ED, we did not substantiate the implied inappropriateness of this condition. VHA Handbook 1101.05, *Emergency Medicine*, requires, at minimum, an RN and a licensed physician credentialed and privileged to be in the ED during all hours of operation. We reviewed the actual ED staffing from September 1 to 7, 2014, and found that CAVHCS met this requirement. During periods of increased volume, physicians from the medical wards provided additional ED support.

Allegation: The ED had inadequate social work coverage.

We did not substantiate the allegation. The social worker assigned to the ED also covered other clinical areas and programs. The ED social worker told us that she got paged to the ED about 1–3 times per week during regular business hours. The Social Work Department also covered the evening and night shifts via an on-call rotation. We did not find evidence that the current ED workload necessitated additional social work staffing.

Conclusions

We substantiated that CAVHCS was not meeting VHA's ED timeliness measures. Our review of 172 patients who received ED care at CAVHCS during the week of September 1–7, 2014, reflected that ED waits were generally due to pending admission, undergoing treatment in the ED, or being sent to another facility for radiology/ultrasound services.

⁶ Female patients or psychiatrically unstable patients would not be placed in a group observation situation.

⁷ A fourth patient, a female, was on special observation in an ED bay.

We did not substantiate that CBOC PC providers would not see walk-in patients; however, CBOC staff confirmed that managing walk-in patients was an ongoing challenge and that some patients elected to go to the ED rather than wait at the CBOC.

We confirmed that patients were sent to other hospitals because CAVHCS did not provide the needed services; however, we did not substantiate the implied inappropriateness of this condition. CAVHCS is not expected or required to provide all medical or ancillary services that a patient may need.

We did not substantiate that patients' vital signs were not being checked as required although we noted that CAVHCS policy only addresses the requirement for reassessment, including vital signs, for patients designated as ESI level 1. We found no documented requirement for reassessment of patients designated as ESI levels 2–5 and were most likely to be waiting for care. While we confirmed that triage notes could be delayed on occasion, we did not substantiate that this was a regular occurrence.

We substantiated that there may have been times when staff were stretched to provide appropriate special observation to MH patients in the ED. Of the 172 patients seen in the ED the week of September 1–7, 2014, we found one situation where one LPN provided the observation for three patients for almost 3 hours. While not prohibited by policy, we question whether this staffing ratio was sufficient to assure patient and staff safety.

We confirmed that only one ED physician was on duty; however, according to VHA guidelines, this is an acceptable practice. We reviewed the actual ED staffing from September 1 to 7, 2014, and found that CAVHCS met this requirement. During periods of increased volume, physicians from the medical wards provided additional ED support.

We did not substantiate the allegation that the ED had inadequate social work coverage. We did not find evidence that the current ED workload necessitated additional social work staffing.

We were unable to fully evaluate seven additional allegations due to insufficient information and/or details. We did not identify conclusive evidence to either sustain or refute these allegations. Those allegations are included in Appendix A.

Recommendations

1. We recommended that the Central Alabama Veterans Health Care System Director charter a systems redesign team to improve the timeliness of care delivery in the Emergency Department.
2. We recommended that the Central Alabama Veterans Health Care System Director revise the Emergency Department triage policy to include reassessment expectations for patients designated as Emergency Severity Index levels 2–5.

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- 3.** We recommended that the Central Alabama Veterans Health Care System Director ensure that adequate staffing is available in the Emergency Department to assure safe special observation to mental health patients.

Allegations Lacking Adequate Detail To Permit Full Review

The allegations listed below were primarily identified through the EAR survey comments. Many of the complaints lacked sufficient detail for us to fully or reasonably evaluate the issues. As noted in the Scope and Methodology section of this report, we **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

Allegation: ED patients were triaged based on the provider, not based on patient need.

We could not substantiate the allegation, as we were unclear about the precise concern. Of the 172 patients who received ED care at CAVHCS during the week of September 1–7, 2014, all were triaged according to CAVHCS protocol, and the triage results were appropriately documented.

Allegation: There was no follow-through on ED patients' complaints.

We could not substantiate the allegation. Without specific details or case examples, we could not fully evaluate whether lack of follow-through on certain complaints represented a deviation from the standard of care. Not all complaints can or should be addressed in the ED; some non-acute complaints are more appropriately managed by the patient's PC provider. In our sample, we found that ED providers consistently addressed patients' presenting problems.

Allegation: Critically ill ED patients were not transferred to a higher level of care on cardiac monitors.

We could not substantiate the allegation. Without specific details or case examples, we could not fully evaluate whether, or under what circumstances, some patients may have been transferred from the ED to the intensive care unit without appropriate monitoring.

CAVHCS' policy on continuous cardiac monitoring defines when patients should be monitored. Of the 172 patients evaluated in the ED from September 1 through 7, 2014, 1 was transferred to the ICU. According to the nurse's progress note, the patient was on continuous cardiac monitoring during transport.

Allegation: PC providers sent patients to the ED for injections.

We could not substantiate the allegation. Without specific details or case examples, we could not fully evaluate the circumstances under which patients may have been sent to the ED, the types of injections allegedly required, and whether those were isolated cases or reflective of a larger systems problem.

Allegation: Community Living Center patients with Do-Not-Attempt Resuscitation (DNAR) orders were sent to the ED for treatment.

We could not substantiate the allegation. Without specific details or case examples, we could not fully evaluate whether it was improper to send patients with DNAR orders to the ED for treatment. According to the American Heart Association, having a DNAR order does not preclude some interventions such as administration of parenteral fluids, nutrition, oxygen, analgesia, sedation, antiarrhythmic agents, or vasopressors.⁸ Depending on the Community Living Center patients' circumstances, it may have been appropriate to send them to the ED for certain treatments.

Allegation: Surgery patients were sent to the ED for hypertension.

We could not substantiate the allegation. Without specific details or case examples, we could not fully evaluate whether it was improper to send some hypertensive surgery patients to the ED for treatment. According to CAVHCS' specialty clinic standard operating procedure, symptomatic patients with blood pressures over 140/90 mm Hg may be sent to the ED for treatment.

Allegation: Patients could wait up to 24 hours in the ED before admission to the acute MH unit in Tuskegee.

We could not substantiate the allegation, as the EAR respondent did not provide specific details or case examples of when such incidences may have occurred. However, we confirmed that patients awaiting acute MH unit admission tended to spend longer in the ED than those patients awaiting medical admissions.

⁸American Heart Association, Ethical Aspects of CPR [cardiopulmonary resuscitation] and ECC [Emergency Cardiovascular Care], http://circ.ahajournals.org/content/102/suppl_1/1-12.full, Retrieved August 3, 2015.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: SEP -9 2015

From: Interim Director, VA Southeast Network (10N7)

Subj: **Draft Report**—Healthcare Inspection—Emergency Department Concerns, Central Alabama VA Health Care System (CAVHCS), Montgomery, Alabama

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. In reference to Status Request—Healthcare Inspection-Emergency Department Concerns, CAVHCS, Montgomery, Alabama, VISN 7 submits the attached documents.
2. I concur with CAVHCS' corrective action plan to address recommendations 1 – 3 as well as the projected completion dates.
3. I appreciate the opportunity to continue in the process to improve the care of our Veterans.
4. If there are any questions, please contact Ms. Brenda Winston, Chief, Quality Management (Brenda.Winston@va.gov 334-272-4670 ext. 6297).



Thomas C. Smith III, FACHE

Attachment

CAVHCS Director Comments

Department of Veterans Affairs

Memorandum

Date: SEP -9 2015

From: Interim Director, Central Alabama Veterans Health Care System (619/00)

Subj: **Draft Report**— Healthcare Inspection—Emergency Department Concerns, CAVHCS, Montgomery, Alabama

To: Interim Director, VA Southeast Network (10N7)

1. I have reviewed the **Draft Report** – Healthcare Inspection – Emergency Department Concerns – for Central Alabama Veterans Health Care System and concur with the report. I appreciate the OIG’s efforts to support CAVHCS’ delivery of the highest quality of care to our Veterans.
2. CAVHCS has developed a corrective action plan to address recommendations 1 – 3 thoroughly and timely. The projected completion dates include time to ensure compliance, appropriate monitoring, and sustainability. The corrective actions are attached.
3. If there are any questions, please contact Ms. Brenda Winston, Chief, Quality Management (Brenda.Winston@va.gov 334-272-4670 ext. 6297).



Traci L. Solt, MSN, NEA-BC, RN-BC, CRRN, CCM, VHA-CM

Director Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Central Alabama Veterans Health Care System Director charter a systems redesign team to improve the timeliness of care delivery in the Emergency Department.

Concur

Target date for completion: September 30, 2015 (to allow time for monitoring and ensuring sustainability)

Facility response:

1. CAVHCS System Redesign Coordinator with the Emergency Room leadership will develop a charter to be signed and approved by the Director. By June 22, 2015
2. Charter team that will consist of ED provider, ED Nurse Manager, front line staff, MH, Social Work, Union Official, CLC, PC, Utilization Management, and systems redesign coordinator. By June 30, 2015
3. Develop measurable /sustainable AIMS with targets.
4. Create Current and Target flow maps to identify gaps and opportunities for improvement.
5. Based on gaps and opportunities identified; create an action plan and track each item to completion.

Recommendation 2. We recommended that the Central Alabama Veterans Health Care System Director revise the Emergency Department triage policy to include reassessment expectations for patients designated as Emergency Severity Index levels 2–5.

Concur

Target date for completion: July 31, 2015

Facility response:

CAVHCS Emergency Department Nursing Triage Policy will be updated to include reassessment expectations for patients designated as Emergency Severity index levels 1-5. By June 19, 2015. The policy will be revised to include the following:

- a. ESI-1 every 5-15 minutes as needed and no less frequently than every hour for the first 4 hours and every 2 hours if clinically stable.
- b. ESI-2 Vital Signs no less frequently than every hour for the first 4 hours and every 2 hours if clinically stable.
- c. ESI-3 Vital Signs no less frequently than every two hour for the first 4 hours and every 4 hours if clinically stable
- d. ESI-4 Vital signs per acuity and clinical assessment but no less than every 4 hours.
- e. ESI-5 Vital signs per acuity and clinical assessment but no less than every 4 hours.

Recommendation 3. We recommended that the Central Alabama Veterans Health Care System Director ensure that adequate staffing is available in the Emergency Department to assure safe special observation to mental health patients.

Concur

Target date for completion: October 31, 2015

Facility response:

Review of current staffing in the emergency department to include staffing mix and complexity. We will:

- 1. Backfill existing RN vacancies in the ED. By July 31, 2015
- 2. Consider converting LPNs to Nursing Assistants grades GS-3-4 to provide additional support for one to one observation requirements. By October 31, 2015
- 3. Train Nursing Assistants specifically on how to care for MH patients with various diagnoses who require one to one observation. By October 31, 2015
- 4. Validate the Nursing Assistants have completed Behavioral Health competencies to perform the duties assigned including direct observations of skills. By October 31, 2015

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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