DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio

HEALTHCARE INSPECTION | REPORT #21-03525-148 | MAY 12, 2022

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess 10 allegations related to the quality of patient care, the management of patient care, and the availability and use of resources through the Urgent Care Center (UCC) at the Chillicothe VA Medical Center (facility) in Ohio.[1]

The first allegation involved a facility urgent care provider sending a patient with a T12 compression fracture to have chiropractic care at the Complementary and Alternative Medicine (CAM) clinic and a week later the patient returned to the UCC with a T12 burst fracture and fractures of the right 11th and 12th ribs.

Veterans Health Administration (VHA) and facility policies require that the sending provider enters a consult, and the receiving provider links the visit note directly to the consult.[2] For a STAT (or a same-day) consult, the sending provider must also contact the receiving provider to discuss the patient's case.

The OIG found that an urgent care provider verbally referred a patient to the CAM clinic for pain management of a T12 compression fracture and not for chiropractic care. However, the OIG found that the urgent care provider did not enter the CAM consult until eight days after seeing the patient.[3] The chiropractors and the clinical massage therapist told the OIG that the standard practice was to review a consult prior to seeing a patient. However, because of the delay in submission of the consult by the urgent care provider, a CAM clinic chiropractor (chiropractor 1) and the clinical massage therapist failed to follow CAM clinic protocols by not having the consult for review prior to seeing the patient on the day of referral. In addition, because the consult was not entered, chiropractor 1 and the clinical massage therapist could not link the visit note to the consult and had no process for documentation when the consult was not entered. As a result, chiropractor 1 and the clinical massage therapist failed to document the care provided to the patient within the electronic health record (EHR).

The patient returned to the UCC on the same day the late consult was entered complaining of ongoing low back pain. A computerized tomography scan showed "an acute burst fracture and acute fractures of the right 11th and 12th ribs." Because of the lack of documentation and provider recall, the OIG could not conclusively determine the relationship between the actions

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] VHA Directive 1232(4), *Consult Processes and Procedures,* August 24, 2016, amended December 14, 2021. Facility Policy Memorandum 00G-03, *Consult Processes and Procedures,* November 19, 2018.

[3] The consult request was for same day, so should have been entered at the time of the request. The urgent care provider failed to do so even after the chiropractor made repeated requests. The OIG was unable to determine why the urgent care provider failed to enter a consult on the day of the request.

taken by chiropractor 1 and the clinical massage therapist and the patient's bone fractures. The OIG believes that the patient's care coordination would have improved for subsequent facility visits by the patient had the urgent care provider entered the consult on the day of the visit, and chiropractor 1 and the clinical massage therapist documented the care provided within the patient's EHR.

The nine additional allegations involved concerns regarding the management of patient care and the availability and use of resources. The OIG reviewed the nine additional allegations and concluded that they were unsupported and lacked merit; therefore, they are not discussed further in this report.

The OIG made two recommendations to the Facility Director related to education of urgent care providers, chiropractors, and clinical massage therapists on the use of consults and the requirement of timely documentation, and conducting an internal review of the CAM program processes related to patient care, reviewing consults, scheduling appointments, checking-in patients, and documentation.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

CAM	Complementary and Alternative Medicine
EHR	electronic health record
OIG	Office of Inspector General
UCC	Urgent Care Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Chillicothe VA Medical Center (facility) in Ohio to assess allegations related to the quality of patient care, the management of patient care, and the availability and use of resources through the Urgent Care Center (UCC).[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 10 and provides primary care, specialty care, nursing home care, acute and chronic mental health services, and runs a seven-day-a-week UCC.[2] The facility operates six community-based outpatient clinics in Ohio.[3] From October 1, 2020, through September 30, 2021, the facility served 22,185 patients and had a total of 295 operating beds, including 55 inpatient beds, 78 domiciliary beds, and 162 community living center beds.[4] The facility is classified as Level 2.[5]

Allegations

On August 22, 2021, the OIG received 10 allegations involving care provided through the UCC. The first allegation involved an urgent care provider sending a patient with a T12 compression fracture to have chiropractic care at the Complementary and Alternative Medicine (CAM) clinic and a week later the patient returned to the UCC with a T12 burst fracture and fractures of the right 11th and 12th ribs.

The nine additional allegations involved concerns regarding the management of patient care and the availability and use of resources. The OIG reviewed the nine additional allegations and concluded that they were unsupported and lacked merit; therefore, they are not discussed further in this report.

---

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] As of January 2021, the UCC's hours of operations were Monday through Sunday 8:00 a.m. – 6:00 p.m.

[3] The six community-based outpatient clinics are in Athens, Cambridge, Lancaster, Marietta, Portsmouth, and Wilmington, Ohio.

[4] According to a facility leader and a UCC provider, in December 2020, VISN leaders decided to close the facility's inpatient beds due to staffing shortages, a reallocation of resources, and the VISN COVID-19 plan. As of October 6, 2021, there was not a plan to reopen the inpatient beds.

[5] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; Level 3 facilities are the least complex.

Scope and Methodology

The OIG initiated the inspection on August 31, 2021, and conducted a virtual site visit from October 4–25, 2021.

The OIG team interviewed the complainant, a patient and family member, facility leaders, and relevant providers and staff.[6]

The OIG team reviewed the identified patients' electronic health records (EHRs) as well as pertinent Veterans Health Administration (VHA) and facility policies and procedures related to urgent care, inter-facility transfers, ordering and reporting of test results; provider privileging information; nurse scheduling and overtime use for the UCC; relevant emails and instant messages discussed during interviews; and other related documents.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

[6] The OIG team interviewed Chiefs of Staff, Quality Management, Primary Care and Employee Health, Medicine, Health Information Management Systems, and Information Technology; the Associate Director for Patient Care Services; Urgent Care providers and nursing staff; Risk Manager; Nurse Expeditor; Pain Management and Complimentary Alternative Medicine providers; a diabetic coordinator; a pharmacist; the acting Patient Safety Manager; the Administrative Officer for Medicine; and the Lab Manager.

Patient Case Summary

The patient is an 87-year-old with a medical history of osteoporosis, chronic low back pain, seizures, and a repaired infrarenal abdominal aortic aneurysm. On a day in 2021 (day 1), while at home, the patient developed left leg numbness and fell, noting subsequent worsening of lower back pain. On day 3, the patient presented to a non-VA community hospital's emergency department and underwent a computerized tomography (CT) scan of the lumbar spine, which showed an acute compression fracture of the T12 vertebrae. The patient was discharged to home with pain medication. Upon finishing the pain medication, the patient noted an increase in low back pain.

On day 8, the patient's family member spoke with a facility nurse who advised the patient to come to the UCC. An urgent care provider documented that the patient was wheelchair bound due to pain, reviewed the day 3 imaging report, and concluded that the patient's ongoing back pain was due to the T12 compression fracture. The urgent care provider spoke with a CAM clinic chiropractor (chiropractor 1) who agreed to see the patient that same afternoon. The patient was transported to the CAM clinic to be evaluated and treated by chiropractor 1 for pain management.

On day 14, the patient's family member contacted a facility nurse reporting that the patient was again experiencing severe low back pain. The patient's family member noted that the day 8 chiropractic treatment "seemed to help [the patient] for a few days" but that the pain had now returned. The nurse scheduled a primary care appointment for the next day. The patient's primary care provider evaluated the patient and noted the patient's history of having a recent chiropractic manipulation [adjustment] with transient improvement but now feeling worse. The patient was prescribed a muscle relaxant and advised to return to the CAM clinic.

On day 16, the patient and a family member presented to the UCC complaining that the patient was experiencing persistent severe back pain and was unable to sleep. The patient's family member requested that the patient be seen again by chiropractor 1. A second urgent care provider evaluated the patient and obtained a CT scan of the patient's lumbar spine. The radiologist's interpretation of the CT scan included an acute T12 burst fracture and acute fractures of the right 11th and 12th ribs. The urgent care provider reviewed the CT scan report showing an acute T12 burst fracture with the patient and family member. The patient was transferred to a non-VA community hospital emergency department for further evaluation. Per the non-VA community hospital discharge summary, the patient was evaluated by neurosurgery, placed in a back brace, provided a wheeled-walker, and discharged to home on day 18.

Also on day 16, the urgent care provider who saw the patient on day 8 entered a delayed consult for the patient to receive pain management from the CAM clinic. On day 19, another CAM clinic

chiropractor (chiropractor 2) reviewed the consult and discontinued the request with the explanation that an "acute fracture is a contraindication for chiropractic care."

Inspection Results

Failure to Follow Complementary and Alternative Medicine Consult Processes

The OIG did not substantiate that an urgent care provider medically cleared and sent a patient with a T12 compression fracture for chiropractic care. A week later the patient returned to the UCC with a burst fracture of the T12 vertebrae and fractures of the right 11th and 12th ribs. The OIG found that the urgent care provider arranged for an end-of-the-day pain management consult with chiropractor 1 in the CAM clinic to address the patient's back pain and failed to enter a consult for the requested care until eight days after the patient received treatment from the CAM providers. This delay in consult creation contributed to chiropractor 1 and the clinical massage therapist failing to follow standard clinic procedures, including reviewing the consult prior to seeing the patient and documenting on the care provided to the patient.

VHA and facility policies outline expectations for all healthcare providers entering consults and documentation protocols.[7] Specifically, the sending provider enters a consult. If entering a STAT (or a same-day) consult, the sending provider must contact the receiving provider to discuss the patient's case. The receiving provider is required to link the visit note directly to the consult. Facility policy states that "All Health Care Professionals are responsible for accurately compiling a concise and relevant account of the patient's health care and entering this into the patient's health record within the [established] timeframes."[8]

Through interviews, the OIG was provided with the following information. The facility's CAM clinic provides several treatment options including pain management, chiropractic care, and clinical massage therapy. To access services, a provider enters a CAM consult. A chiropractor reviews the consult and determines what services would be most appropriate for the patient's need. If clinical massage therapy is indicated, the chiropractor forwards the consult to the clinical massage therapist for consideration. Once care within the CAM clinic is determined appropriate, the patient is scheduled for an appointment. Appointments may be available to UCC patients on the same day the consults are entered. For initial appointments, CAM providers link the visit notes to the consult. For subsequent appointments, CAM providers write progress notes.

[7] VHA Directive 1232(4), *Consult Processes and Procedures,* August 24, 2016, amended December 14, 2021. Facility Policy Memorandum 00G-03, *Consult Processes and Procedures,* November 19, 2018.

[8] Facility Policy Memorandum 11-22, *Health Information Management and Documentation Procedures*, June 13, 2017.

Urgent Care Provider

The OIG found that the urgent care provider did not refer the patient for chiropractic care. Rather, the urgent care provider assessed the patient's condition on day 8 and documented the disposition care plan as "patient has been referred to pain management. Spoke with [chiropractor 1] who agreed to see patient today" and patient was stable for transfer. The urgent care provider failed to enter the CAM consult until eight days later even after receiving multiple requests from chiropractor 1. The OIG was unable to determine why there was a delay in consult entry. The urgent care provider's failure to enter the consult timely contributed to the events that followed.

CAM Protocol—Chiropractic Care

The OIG found that chiropractor 1 did not document in the patient's EHR and did not follow CAM protocols for this patient.

Chiropractor 1 explained to the OIG that standard practice for new patients included reviewing the CAM consult and any relevant imaging studies prior to seeing the patient, even patients seen on the same day, and linking documentation to the consult. As the consult was not entered until eight days later, chiropractor 1 did not review the consult prior to seeing the patient and did not document the care provided to the patient on day 8. Chiropractor 1 could not recall this patient.

According to the patient and patient's family member, the patient was seen in the UCC on day 8 for low back pain, and then sent to the CAM clinic. Chiropractor 1 and a chiropractic student evaluated and treated the patient for pain. The patient was then seen by the clinical massage therapist before returning home with family. The patient and patient's family member both recalled being told that several treatments could be required before the pain was alleviated. When the patient's family member called the CAM clinic to schedule further appointments, CAM clinic staff had no record that an initial appointment occurred. The patient did not receive follow-up treatment from either chiropractor 1 or the clinical massage therapist.

CAM Protocol—Clinical Massage Therapy

The OIG found that chiropractor 1 did not follow CAM protocols when referring the patient for clinical massage therapy.

Since there was no CAM consult entered, chiropractor 1 could not forward the consult to the clinical massage therapist for review. Therefore, the clinical massage therapist could not review the consult prior to seeing the patient or document care provided to the patient on day 8.

The clinical massage therapist did not remember the name of the patient but recalled treating a patient who presented with a similar problem. The clinical massage therapist recalled that a consult was not entered, rather that chiropractor 1 requested the patient be seen for pain management. Unsure how to document in the patient's EHR without a consult, the clinical

massage therapist reported sending a brief synopsis of care provided to an unnamed patient on day 8 through instant messaging to chiropractor 1.

Conclusion

The OIG concluded that the urgent care provider referred the patient to the CAM clinic for pain management of a T12 compression fracture. However, the OIG found that the urgent care provider's delay in entering a CAM clinic consult contributed to the failure of chiropractor 1 and the clinical massage therapist in following CAM clinic protocols by not reviewing the consult prior to seeing the patient and failing to document the care provided to the patient. The OIG found that chiropractor 1 and a chiropractic student provided chiropractic care to the patient in an attempt to alleviate the patient's pain, followed by massage therapy. The patient was elderly and had a history of osteoporosis. The hands-on treatment provided to this patient was accompanied by some pain. The lumbar spine CT scan taken about a week after this treatment revealed an acute burst fracture of the T12 vertebrae and fractures of the right 11th and 12th ribs. It is unclear when these fractures occurred or what knowledge the CAM treatment team possessed on day 8, when they planned and provided treatment. Therefore, the OIG could not determine the relationship between the CAM treatment and the patient's bone fractures. The OIG believes that the patient's care coordination would have improved for subsequent facility visits by the patient had the urgent care provider entered the consult on day 8, and chiropractor 1 and the clinical massage therapist documented the care provided within the patient's EHR.

Recommendations 1–2

1. The Chillicothe VA Medical Center Director ensures urgent care providers, chiropractors, and clinical massage therapists are educated on consult processes and procedures and the requirement of timely documentation.
2. The Chillicothe VA Medical Center Director conducts an internal review of the Complementary and Alternative Medicine Program processes related to patient care including receiving and reviewing consults, scheduling appointments, checking-in patients for care, and documentation.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 13, 2022

From: Acting Network Director, VISN 10 (10N10)

Subj: Healthcare Inspection—Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio

To: Director, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I appreciate the opportunity to review and comment on the Office of Inspector General (OIG) draft report for *Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio.*
2. I have reviewed the report and concur with the findings, recommendations and submitted action plans detailed in the Facility Director's memorandum. I am committed to supporting the actions needed to resolve these recommendations.
3. The attachment contains the comments and actions addressing the recommendations in the report.

Thank you,

(*Original signed by*:)

Ronald E. Stertzbach P.E.
Acting Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 5, 2022

From: Director, Chillicothe VA Medical Center (538/00)

Subj: Healthcare Inspection—Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio

To: Director, Veterans Integrated Service Network 10 (10N10)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report for *Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio.*
2. I have reviewed the report and concur with the findings, recommendations and submitted action plans. Please find the facility response to the draft report attached.

(*Original signed by*:)

Kathy W. Berger
Medical Center Director

Facility Director Response

Recommendation 1

The Chillicothe VA Medical Center Director ensures urgent care providers, chiropractors, and clinical massage therapists are educated on consult processes and procedures and the requirement of timely documentation.

Concur.

Target date for completion: May 13, 2022

Director Comments

The urgent care providers, chiropractors, and clinical massage therapists will be reeducated on the use of consults and the requirement of timely documentation. 100% of the reeducation will be completed by May 13, 2022.

Reeducation on the use of consults and the requirement of timely documentation was initiated for Urgent Care providers on April 5, 2022, with the review of VHA Directive 1232(4), Consult Processes and Procedures. The remaining urgent care providers, chiropractors, and clinical massage therapists will be educated by May 13, 2022.

Recommendation 2

The Chillicothe VA Medical Center Director conducts an internal review of the Complementary and Alternative Medicine Program processes related to patient care including receiving and reviewing consults, scheduling appointments, checking-in patients for care, and documentation.

Concur.

Target date for completion: April 1, 2022

Director Comments

An internal review of Complementary and Alternative Medicine Program processes was conducted on April 1, 2022, by the Associate Chief of Specialty Integrated Clinical Community. The facility has established processes. No additional gaps were identified. Facility requests closure of this recommendation.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Glossary

To go back, press "alt" and "left arrow" keys.

abdominal aortic aneurysm. "An aortic aneurysm is a bulging, weakened area in the wall of the aorta [a large artery that runs through the torso]. Over time, the blood vessel balloons and is at risk for bursting (rupture) or separating (dissection). This can cause life threatening bleeding and potentially death."[1]

adjustment. "Manual or mechanical manipulation of a joint (especially the spine) in which a controlled force is applied to the joint."[2]

burst fracture. "… an injury in which the vertebra, the primary bone of the spine, breaks in multiple directions."[3]

chiropractic care. Noninvasive therapy that focuses treatment on the manual adjustment or manipulation of the spinal vertebrae.[4]

clinical massage therapy. "Manipulation of the soft tissues of the human body for therapeutic purposes."[5]

Complementary and Alternative Medicine. "A group of medical and health care systems, practices, and products not presently considered to be part of conventional medicine."[6]

compression fracture. "A type of broken bone that can cause vertebrae to collapse, making them shorter."[7]

[1] Johns Hopkins Medicine, "abdominal aortic aneurysm," accessed November 16, 2021, https://www.hopkinsmedicine.org/health/conditions-and-diseases/abdominal-aortic-aneurysm.

[2] *Merriam-Webster.com Dictionary,* "adjustment," accessed November 16, 2021, https://www.merriam-webster.com/dictionary/adjustment.

[3] Columbia University, "burst fracture," accessed December 1, 2021, https://www.neurosurgery.columbia.edu/patient-care/conditions/burst-fracture.

[4] *Merriam-Webster.com Dictionary,* "chiropractic," accessed November 17, 2021, https://www.merriam-webster.com/dictionary/chiropractic.

[5] VA, Office of Patient Centered Care and Cultural Transformation, *Massage Therapy in VA – Fact Sheet,* accessed November 16, 2021.

[6] VHA Directive 1137(2), *Provision of Complementary and Integrative Health,* May 18, 2017, amended July 2, 2021.

[7] Johns Hopkins Medicine, "compression fractures," accessed November 17, 2021, https://www.hopkinsmedicine.org/health/conditions-and-diseases/compression-fractures.

computerized tomography scan. "Combines a series of x-ray images taken from different angles around [the] body and uses computer processing to create cross-sectional images."[8]

consult. "A consult is a request for clinical services on behalf of a patient. In VHA, consult requests are made through an electronic document communicating service requests and/or results."[9]

infrarenal. "Situated or occurring below the kidneys."[10]

neurosurgery. "Surgery of nervous structures (such as nerves, the brain, or the spinal cord)."[11]

osteoporosis. A condition that "causes bones to become weak and brittle…Osteoporosis-related fractures most commonly occur in the hip, wrist or spine."[12]

T12. Lowest vertebra of the thoracic, or middle back, part of the spine.[13]

Urgent Care Center. Provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[14]

vertebrae. "One of the bony or cartilaginous segments composing the spinal column."[15]

[8] Mayo Clinic, "CT scan," accessed September 8, 2021, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[9] Facility Policy Memorandum 00G-03, *Consult Processes and Procedures,* November 19, 2018.

[10] *Merriam-Webster.com Dictionary,* "infrarenal," accessed December 8, 2021, https://www.merriam-webster.com/medical/infrarenal.

[11] *Merriam-Webster.com Dictionary,* "neurosurgery," accessed December 8, 2021, https://www.merriam-webster.com/dictionary/neurosurgery.

[12] Mayo Clinic, "Osteoporosis," accessed February 16, 2022, https://www.mayoclinic.org/diseases-conditions/osteoporosis/symptoms-causes/syc-20351968.

[13] Cleveland Clinic, "Spine Structure and Function," accessed November 17, 2021, https://my.clevelandclinic.org/health/articles/10040-spine-structure-and-function.

[14] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

[15] *Merriam-Webster.com Dictionary,* "vertebra," accessed November 17, 2021, https://www.merriam-webster.com/dictionary/vertebra.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joanne Wasko, MSW, LCSW, Director Lisa Barnes, MSW Katherine Bostick, MPH, LCSW Limin Clegg, PhD Debbie Davis, JD Thomas Jamieson, MD Hanna Lin, LCSW Seema Maroo, MD Aja Parchman, MHA, RN Erika Terrazas, MS Sonia Whig, MS, LDN
Other Contributors	Shelby Assad, LCSW Sherry Becker, MSN, RN-BC Karen Berthiaume, RPh, BS Jennifer Christensen, DPM Sheena Mesa, MSN, RN Daphney Morris, MSN, RN Natalie Sadow, MBA Zaire Smith, LCSW Erica Taylor, MSW, LICSW April Terenzi, BA, BS Dawn Woltemath, MSN, RN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 10 (10N10)
Director, Chillicothe VA Medical Center: (538/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, Rob Portman
U.S. House of Representatives: Mike Carey, Bill Johnson, Brad Wenstrup

OIG reports are available at www.va.gov/oig.