



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Summary Report:
Evaluation of Quality, Safety,
and Value in Veterans
Health Administration
Facilities, Fiscal Year 2021



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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
QSV	quality, safety, and value
VHA	Veterans Health Administration



Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected quality, safety, and value program requirements for committees with oversight functions, systems redesign and improvement, protected peer reviews of clinical care, and medical center surgical programs.

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.¹

Inspection Results

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with

- peer review committees' recommendation of individual improvement actions for Level 3 peer reviews,²
- establishment of surgical work groups with required members who meet at least monthly, and
- surgical work groups' monthly review of surgical deaths.

¹ Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

² A peer review is a "critical review of care performed by a peer" to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Conclusion

The OIG conducted detailed inspections at 45 VHA facilities to ensure staff implemented selected quality, safety, and value processes. The OIG subsequently issued three recommendations for improvement to the Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

VA Comments

The Under Secretary for Health concurred with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, page 13, and the responses within the body of the report for the full text of the executive's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Contents

Abbreviations	ii
Report Overview	iii
Inspection Results	iii
Purpose and Scope	1
Methodology	4
Results and Recommendations	5
Recommendation 1	6
Recommendation 2	7
Recommendation 3	9
Appendix A: Comprehensive Healthcare Inspection Program Recommendations	10
Appendix B: Parent Facilities Inspected	11
Appendix C: Under Secretary for Health Comments	13
OIG Contact and Staff Acknowledgments	14
Report Distribution	15



Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and assesses specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' quality, safety, and value (QSV) programs is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.¹ These leaders are directly accountable for program integration and communication within their level of responsibility.

To determine whether VHA implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the OIG evaluated facility committees responsible for QSV oversight functions; their ability to review data, information, and risk intelligence; and their ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed facilities' processes for their systems redesign and improvement programs, which support "VHA's transformation journey to become a High Reliability Organization."² Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."³ The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects

¹ Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).

² VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

³ VHA Directive 1026.01.

- Participation on the facility quality management committee and Veterans Integrated Service Network Systems Redesign Review Advisory Group⁴
- Staff education on performance improvement principles and techniques

Next, the OIG assessed the facilities' processes for conducting protected peer reviews of clinical care.⁵ Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."⁶ Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.⁷ The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁸
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁹
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the facilities' surgical programs. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."¹⁰ The National Surgery Office's principles, which guide

⁴ VA administers healthcare services through a nationwide network of 18 regional offices referred to as Veterans Integrated Service Networks.

⁵ A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705, "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

⁶ VHA Directive 1190.

⁷ VHA Directive 1190.

⁸ VHA Directive 1190.

⁹ A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

¹⁰ "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program SharePoint site.

the delivery of comprehensive surgical services at local, regional, and national levels, include “(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs.”¹¹ Facility performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events¹²

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.¹³

¹¹ “NSO Reporting, Resources, & Tools.”

¹² VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

¹³ Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

Methodology

The OIG evaluated compliance with selected QSV program requirements through comprehensive healthcare inspections of 45 VHA medical facilities during fiscal year 2021. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

To determine compliance and assess care quality, safety, and value, the OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.¹⁴

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from individual facility inspections to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. The comments and action plans submitted by the Under Secretary for Health in response to the recommendations appear within the report. The OIG accepted the action plans that the Under Secretary for Health developed based on the reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.¹⁵ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

¹⁴ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

¹⁵ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.¹⁶ To meet this goal, VHA requires that its medical facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain The Joint Commission accreditation.¹⁷ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."¹⁸

The OIG found general compliance with many of the selected requirements. However, across the facilities inspected in fiscal year 2021, the OIG identified weaknesses in the following key QSV functions:

- Peer review committees' recommendation of individual improvement actions for Level 3 peer reviews
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work groups' monthly review of surgical deaths

VHA requires facility peer review committees to complete final reviews of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of healthcare delivered."¹⁹ The OIG found that 27 of 211 Level 3 peer reviews (13 percent) did not contain evidence that peer review committees recommended improvement actions, which likely prevented improvements in providers' patient care practices. Reasons for noncompliance included the belief that facility efforts met the requirement, lack of peer review program operation monitoring, and peer review committee member perceptions that individual improvement actions were punitive.

¹⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

¹⁷ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

¹⁸ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

¹⁹ VHA Directive 1190.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facility peer review committees recommend improvement actions for Level 3 peer reviews.

VHA concurred.

Target date for completion: April 2023

Under Secretary for Health response: The Office of Medical-Legal Risk Management (MLRM) concurs with the recommendation. As described in Appendix A of VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, the Peer Review Committee (PRC) is responsible for providing:

- Final level assignment, in writing, for all cases brought before the PRC.
- Recommendations for non-punitive, non-disciplinary actions to improve the quality of health care delivered or the utilization of health care resources.

The supervisor of the individual who was reviewed is responsible for initiating appropriate action and follow-up.

- The supervisor of the individual(s) that was assigned a Level 2 or Level 3 will communicate with the individual(s) in their service and ensure that appropriate action is implemented.
- The supervisor must notify the PRC upon completion of the appropriate action and follow up.

The Office of MLRM considered the reasons of non-compliance when developing the action plan. MLRM will provide a template to each Veterans Integrated Service Network (VISN) Risk Management Liaison. This template will list every Level 3 finding for each facility and show snippets of the minutes to ensure recommendations are included. The VISN will attest to the accuracy of the minutes and if each snippet meets the requirement of incorporating recommendations. This template will be submitted monthly to MLRM. If a facility reports the committee did not meet in that month, that must be included in the submission to MLRM.

The VISN will require each facility to submit all of their Level 3 cases including snippets of their minutes to the VISN Risk Management Liaison after each meeting. This template will be submitted monthly to the VISN Liaison. If a committee did not meet in that month, that information must be relayed to the VISN Liaison.

MLRM will monitor until 90% compliance is maintained for 6 consecutive monthly submissions.

VHA requires medical facility directors to ensure that facilities with surgery programs have a surgical work group that meets at least monthly and includes the chief of staff, surgical quality nurse, and operating room nurse manager.²⁰ The OIG reviewed meeting minutes from 40 facility-level surgical work groups and found that 9 groups (23 percent) did not consistently meet monthly.²¹ Reasons for noncompliance included facility leaders canceling meetings due to the COVID-19 pandemic and committee members failing to attend.

Further, the OIG found that 21 chiefs of staff (53 percent), 8 operating room nurse managers (20 percent), and 5 surgical quality nurses (13 percent) did not consistently attend their respective surgical work group meetings. The lack of monthly meetings and core member attendance resulted in missed opportunities for oversight and review of surgery program activities with key staff. Reasons for noncompliance included members' unawareness of requirements, lack of assigned alternates, and competing priorities.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility surgical work groups meet monthly and core members consistently attend meetings.

²⁰ VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

²¹ The Edith Nourse Rogers Memorial Veterans' Hospital (Bedford, MA), Sheridan VA Medical Center (WY), VA Central Western Massachusetts Healthcare System (Leeds, MA), VA Finger Lakes Healthcare System (Bath, NY), and VA Hudson Valley Health Care System (Montrose, NY) do not have surgical programs.

VHA concurred.

Target date for completion: October 2022

Under Secretary for Health response: Directive 1102.01(1) requires the Facility Surgical Work Group to meet monthly; defines the Chief of Surgery as Chair; and specifies required members to include Chief of Staff, facility Surgical Quality Nurse, and facility Operating Room Nurse Manager.

The National Surgery Office will:

- Formally communicate with VISN Chief Surgical Consultants through Network Directors to confirm policy requirements for Facility Surgical Workgroup membership and attendance (Directive 1102.01(1) National Surgery Office (NSO)).
- Assign VISN Surgery Workgroup oversight for quarterly review of Facility Surgery Workgroup attendance.
- Define expectation for twelve Facility Surgery Workgroup meetings per year, conducted approximately monthly;
- Define expectation for key required members of the Facility Surgery Workgroup for demonstration of meaningful participation by personal attendance at meetings (threshold: minimum of 9 meetings annually, with appropriate delegation to an acting official for meetings not personally attended);
- Require that facility surgery programs share Facility Surgery Workgroup meeting minutes and attendance with the VISN Surgical Workgroup (VSW) at least quarterly for oversight of compliance including recommendation for corrective action plans to impacted facilities;
- Require facility reporting of compliance at annual surgical summits with NSO beginning in FY23; and,
- Will continue monitoring for a minimum of two fiscal years to assess compliance.

VHA requires medical facilities with surgery programs to have a surgical work group responsible for “monthly review of surgical deaths...analysis of efficiency and utilization metrics...review of NSO [National Surgery Office] surgical quality reports; and...evaluation of critical surgical events.”²² The OIG reviewed meeting minutes from 40 facility-level surgical work groups and did not find evidence that 5 groups (13 percent) consistently reviewed surgical deaths. Failure to review and analyze surgical data may have resulted in missed opportunities to improve patient safety in the surgical program. Reasons for noncompliance included members’ unawareness of requirements and facility leaders’ review of surgical deaths outside the surgical work group, rendering surgical work group review redundant.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facility surgical work groups consistently review surgical deaths.

VHA concurred.

Target date for completion: October 2022

Under Secretary for Health response: Directive 1102.01(1) defines the duties and responsibilities of the Facility Surgical Work Group. These duties include: A monthly review of surgical deaths.

The National Surgery Office will:

- Formally communicate with VISN Chief Surgical Consultants through Network Directors to confirm policy requirements for Facility Surgical Workgroups to conduct a monthly review of surgical deaths (Directive 1102.01(1) National Surgery Office). Assign VISN Surgery Workgroup oversight for quarterly review of Facility Surgery Workgroup agenda to include review of surgical deaths.

²² VHA Directive 1102.01(2).

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program 	<ul style="list-style-type: none"> • Facility peer review committees recommend improvement actions for Level 3 peer reviews. • Facility surgical work groups consistently review surgical deaths. 	<ul style="list-style-type: none"> • Facility surgical work groups meet monthly and core members consistently attend meetings.

Appendix B: Parent Facilities Inspected

**Table B.1. Parent Facilities Inspected
(October 1, 2020, through September 30, 2021)**

Names	City
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Charles George VA Medical Center	Asheville, NC
Cheyenne VA Medical Center	Cheyenne, WY
Durham VA Health Care System	Durham, NC
Eastern Oklahoma VA Health Care System	Muskogee, OK
Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA
Fayetteville VA Coastal Health Care System	Fayetteville, NC
Hampton VA Medical Center	Hampton, VA
Hershel "Woody" Williams VA Medical Center	Huntington, WV
Hunter Holmes McGuire VA Medical Center	Richmond, VA
James A. Haley Veterans' Hospital	Tampa, FL
James J. Peters VA Medical Center	Bronx, NY
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester, NH
Martinsburg VA Medical Center	Martinsburg, WV
Miami VA Healthcare System	Miami, FL
Montana VA Health Care System	Fort Harrison, MT
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
Orlando VA Healthcare System	Orlando, FL
Providence VA Medical Center	Providence, RI
Salem VA Medical Center	Salem, VA
Samuel S. Stratton VA Medical Center	Albany, NY
Sheridan VA Medical Center	Sheridan, WY
Syracuse VA Medical Center	Syracuse, NY
VA Boston Healthcare System	Jamaica Plain, MA
VA Caribbean Healthcare System	San Juan, PR

Names	City
VA Central Western Massachusetts Healthcare System	Leeds, MA
VA Connecticut Healthcare System	West Haven, CT
VA Eastern Colorado Health Care System	Aurora, CO
VA Finger Lakes Healthcare System	Bath, NY
VA Hudson Valley Health Care System	Montrose, NY
VA Maine Healthcare System	Augusta, ME
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA New York Harbor Healthcare System	New York, NY
VA Salt Lake City Health Care System	Salt Lake City, UT
VA Western Colorado Health Care System	Grand Junction, CO
VA Western New York Healthcare System	Buffalo, NY
W.G. (Bill) Hefner VA Medical Center	Salisbury, NC
Washington DC VA Medical Center	Washington, DC
West Palm Beach VA Medical Center	West Palm Beach, FL
White River Junction VA Medical Center	White River Junction, VT

Source: VA OIG.

Appendix C: Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 28, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report:
Evaluation of Quality, Safety, and Value in Veterans Health Administration
Facilities, Fiscal Year 2021 (2022-00818-HI-1235) (VIEWS 8352368)

To: Office of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

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