DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)

CITC REPORT | REPORT #21-01823-31 | JANUARY 12, 2023

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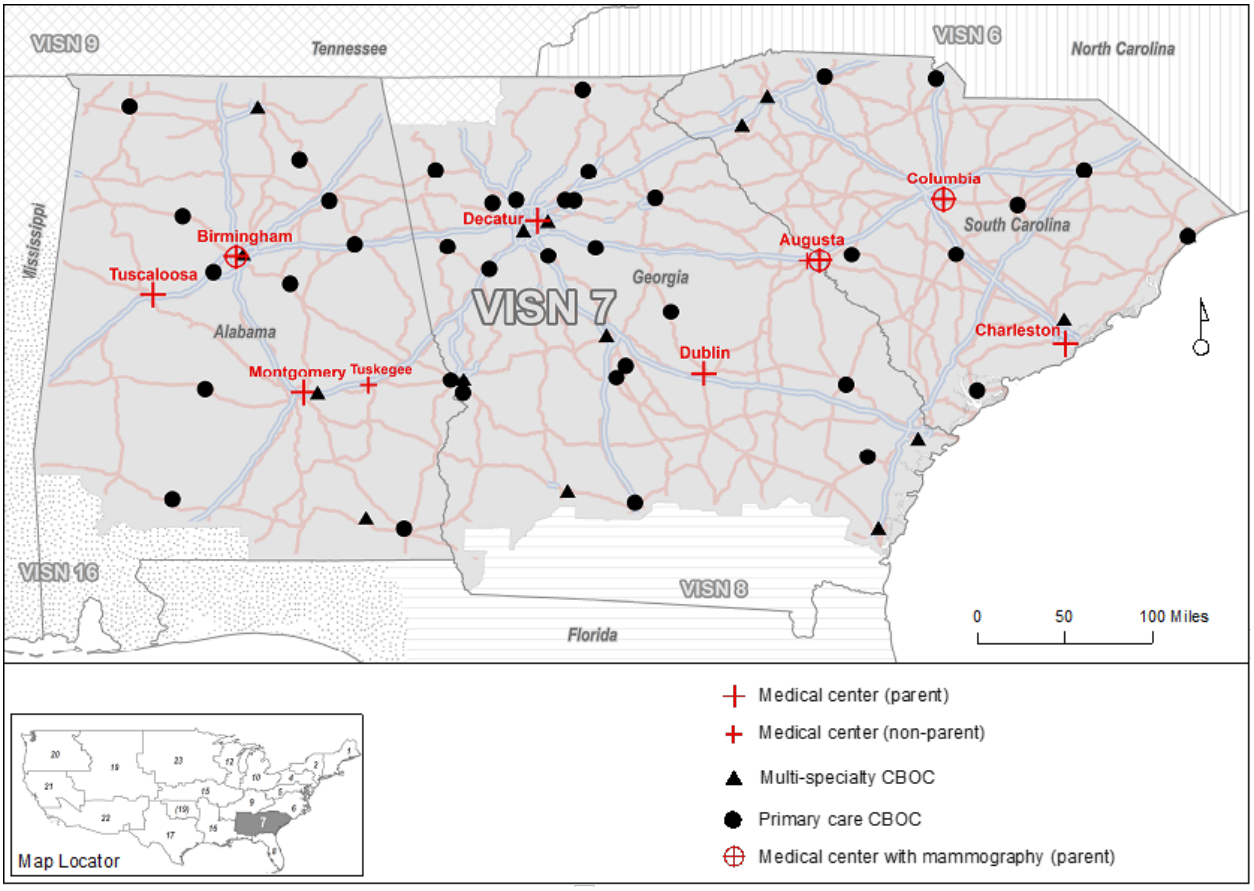

Figure 1. *Veterans Integrated Service Network 7: VA Southeast Network.*

Source: Veterans Health Administration Support Service Center, accessed August 23, 2021.

Abbreviations

CBOC	community-based outpatient clinic
CHF	congestive heart failure
CI	confidence interval
CITC	Care in the Community
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Office of Inspector General (OIG) Care in the Community (CITC) healthcare inspection program examines key clinical and administrative processes that are associated with providing quality VA and community (non-VA) care. CITC inspections are one element of the OIG's overall oversight efforts to ensure that veterans receive high-quality and timely healthcare services.

In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated VA community care programs into the Veterans Community Care Program.[1] This program simplified the process for veterans to receive non-VA care by expanding eligibility criteria, improving customer service, and providing a way for patients to access in-network walk-in care without requiring prior authorization.[2]

The OIG oversees the Veterans Health Administration's (VHA's) clinical efforts with the implementation of the MISSION Act by selecting and evaluating specific areas of focus on a rotating basis. This report provides a focused evaluation of Veterans Integrated Service Network (VISN) 7: VA Southeast Network and its oversight of the quality of care delivered in its community-based outpatient clinics and through community care referrals to non-VA providers.[3] VISN leaders are responsible for ensuring that care, treatment, and services are provided safely and effectively regardless of whether they are delivered by VA or non-VA providers.[4]

The OIG performed an unannounced virtual inspection of VISN 7 from August 23 through September 2, 2021, and reviewed four clinical and administrative areas of focus:

- Care coordination: congestive heart failure management
- Primary and mental health care: diagnostic evaluations following positive screenings for depression or alcohol misuse
- Quality of care: home dialysis care
- Women's health: mammography services and communication of results

The findings presented in this report are a snapshot of VISN 7 care provided in community-based settings, which includes VA and non-VA care, within the identified focus areas at the time of the OIG inspection. Although it is difficult to measure the value of well-delivered and

[1] The VA MISSION Act of 2018, Pub. L. No. 115-182, § 132 (2018).

[2] VHA Office of Community Care, "Veteran Community Care General Information Fact Sheet," September 9, 2019.

[3] VHA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[4] "Care, treatment, and services provided through contractual agreement are provided safely and effectively." The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021.

coordinated care between VA and non-VA providers, the findings may help VISN leaders identify vulnerable areas of community care that, if properly addressed, could improve healthcare quality for veterans.

Inspection Results

Care Coordination: Congestive Heart Failure Management

The OIG found that community-based outpatient clinic primary care providers managed congestive heart failure patients in accordance with existing VHA guidance, including staff addressing patients' elevated blood pressure and conducting post-discharge follow-up, patient education, and medication reconciliation.

Primary and Mental Health Care: Diagnostic Evaluations

The OIG determined that patients screened and identified to be at risk for depression or alcohol use disorder received further diagnostic evaluations in compliance with VHA requirements. The OIG also found that staff processed patients' referrals to specialty care in accordance with timeliness requirements.

Quality of Care: Home Dialysis

The OIG determined that patients who received non-VA home dialysis generally reported care in accordance with VHA's program requirements. However, VHA does not require documentation of ongoing, routine care by non-VA providers for patients referred to home dialysis. Without documentation for review, VISN leaders, providers, and program staff could not monitor the quality of contracted clinical services for non-VA home dialysis patients.

Women's Health: Mammography Services and Communication of Results

The OIG team observed compliance with most of the required elements of performance, including ordering providers receiving mammogram results within 30 days of the procedure. However, the OIG found that providers who referred patients for mammography did not document they communicated the normal result to the patient within the required 14-day time frame.

Conclusion

The OIG conducted a review across four key clinical and administrative areas and issued two recommendations for improvement to the VISN 7 Director. The number of recommendations should not be used as a gauge for the overall quality of care provided in VISN 7. The intent is for

the VISN Director and other leaders to use these recommendations to help guide improvements in their oversight of operations and clinical care.

VA Comments

The VISN 7 Director agreed with the findings and recommendations and provided acceptable improvement plans (see appendix D, page 26, and the responses within the body of the report for the full text of the VISN Director's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The Office of Inspector General (OIG) Care in the Community (CITC) inspection program provides oversight in the provision of care delivered in Veterans Health Administration (VHA) community-based outpatient clinics (CBOCs) and through contracted non-VA care providers.

The OIG conducted this inspection of Veterans Integrated Service Network (VISN) 7: VA Southeast Network, which is responsible for oversight of the care provided by its associated medical facilities, CBOCs, and contracted providers.[1] This includes ensuring that care, treatment, and services are provided safely and effectively regardless of whether they are delivered by VA or non-VA providers.[2] Leaders make decisions that directly or indirectly affect every aspect of operations. They create policies and procedures and secure resources that support patient safety and quality care, treatment, and services.[3] This focused review examined key clinical and administrative processes associated with quality care and positive patient outcomes.

To examine the provision of care provided in community-based settings by VA and contracted non-VA providers, the OIG focused on core processes in the following four areas of clinical and administrative operations:

- Care coordination: congestive heart failure (CHF) management
- Primary and mental health care: diagnostic evaluations following positive screenings for depression or alcohol misuse
- Quality of care: home dialysis care
- Women's health: mammography services and communication of results

The findings presented in this report are a snapshot of VISN 7 compliance with VHA requirements and The Joint Commission standards in identified focus areas from July 1, 2019, through June 30, 2020. The OIG reports these findings to VISN leaders so they can make informed decisions to improve care (see appendix A for a summary table of the OIG's recommendations).

[1] VHA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] "Care, treatment, and services provided through contractual agreement are provided safely and effectively." The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021.

[3] "The organization effectively manages its programs, services, or sites." The Joint Commission, *Standards Manual*, LD.04.01.05, July 2021.

Background

Veterans Integrated Service Networks

A VISN is a regional system of VHA healthcare facilities. VHA established 18 VISNs to meet local healthcare needs and provide greater access to care.[4] A VISN covers a geographic area defined by patient referral patterns, numbers of veteran beneficiaries and facilities needed to provide and support care, and boundaries such as state borders. Under the VISN model, care is provided at VA medical centers and CBOCs and through contractual or sharing agreements with non-VA providers. In VA's healthcare system, the VISN is "the basic budgetary and planning" entity.[5]

In general, a VISN director is responsible for ensuring implementation of VA policies; providing leadership that supports and promotes delivery of comprehensive, coordinated care; and "ensuring all facilities in the VISN are adequately staffed and resourced" to "achieve national and local…performance and quality improvement goals."[6]

The VA Southeast Network (VISN 7) includes sites in Alabama, Georgia, and South Carolina. This VISN serves 1.2 million enrolled veterans receiving care throughout eight medical centers and 50 CBOCs.[7] Prior to the COVID pandemic, the VISN had spent over $648 million on non-VA care in fiscal year 2019.

Community-Based Outpatient Clinics

A CBOC is an outpatient site of healthcare services geographically located apart from a VHA medical facility. VHA uses CBOCs to make VA health care more accessible to veterans and reduce their need to visit a larger medical center for outpatient care.[8] CBOCs provide primary, specialty, and mental health care, or any combination of these and operate from one to seven days per week.[9]

VHA classifies these remotely located clinics as primary care or multi-specialty CBOCs or healthcare centers, depending on the complexity, number, and types of services provided.

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[4] "About VHA," VHA, accessed July 23, 2020, https://www.va.gov/health/aboutvha.asp.

[5] Statement of Carolyn Clancy, MD, VHA Executive in Charge, before the House Committee on Veterans' Affairs, May 22, 2018, accessed July 1, 2021, https://docs.house.gov/meetings/VR/VR00/20180522/108328/HHRG-115-VR00-Wstate-ClancyC-20180522.pdf.

[6] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017.

[7] "About Us - VA Southeast Network (VISN7)," accessed March 21, 2022, https://www.southeast.va.gov/SOUTHEAST/about/index.asp.

[8] "About VHA," VHA website.

[9] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

Primary care CBOCs offer both medical and mental health care. Multi-specialty CBOCs offer primary and mental health care as well as two or more specialty care services.[10] Additional details about the CBOCs within VISN 7 can be found in appendix B.

Community Care

VHA leaders are responsible for providing oversight to ensure direct care, treatment, and services, including contracted services, are safe and effective. Patients should receive the same level of care regardless of whether it is delivered by VA or non-VA providers.[11]

In 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated VA community care programs into the Veterans Community Care Program.[12] This program simplified veterans' access to non-VA care by expanding eligibility criteria, improving customer service, and providing a way for patients to access in-network walk-in care without requiring prior authorization.[13]

The goal of VHA's Office of Community Care (OCC) is to deliver a single, established program that is "easy to understand, simple to administer, and meets the needs of veterans, their families, community providers, and VA staff."[14] VHA facility providers may refer care to non-VA providers for eligible veterans who chose care in the community. Community care may also help VHA leaders ensure timely treatment or allow access to procedures that may not be available through VHA providers.[15] The OCC's *Field Guidebook* outlines the requirements, processes, and tools related to eligibility, referral, and care coordination. It also provides guidance for VA staff managing non-VA care consults, appointment scheduling, and communication between VA and non-VA providers.[16]

The ordering provider initiates the non-VA care referral process by placing a consult request for non-VA care. OCC staff then determine if the care is available at VHA, or if the veteran is eligible for referral to a non-VA provider. Depending on VHA facility operations and patient preference, appointments may be scheduled by

- OCC staff,

[10] VHA Handbook 1006.02.

[11] "Care, treatment, and services provided through contractual agreement are provided safely and effectively." The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[12] The VA MISSION Act of 2018, Pub. L. No. 115-182, § 132 (2018).

[13] VHA Office of Community Care, Fact Sheet, "Veteran Community Care General Information," September 9, 2019.

[14] VHA Office of Community Care (OCC), *Field Guidebook*, chap 1: "Introduction to the Community Care Network," updated July 1, 2021.

[15] VHA OCC, *Field Guidebook*, chap 1.

[16] VHA OCC, "Field Guidebook Landing Page."

- the patient,
- the community provider,
- third-party administrator staff, or
- any combination of these.[17]

When patients schedule appointments for themselves directly with community providers, OCC staff instruct the patients to contact them with the date and time of the appointment. If a patient does not provide the appointment date, OCC staff are not required to contact patients to obtain the appointment information. In that event, OCC staff wait 30 days from the date the patient elected to self-schedule and then contact the community provider to obtain and record the appointment information.[18] Patients' self-scheduled appointments are excluded from certain VHA timeliness reporting requirements, for example, when consults are in an active status for greater than 30 days.[19]

Non-VA providers are responsible for sending medical record documentation to ordering providers within 30 days of completed appointments.[20] Non-VA providers can return the documentation through a variety of methods, including the fee-basis claim system, the Health Share Referral Manager platform, a third-party administrator's portal, electronic fax, other electronic means, or through the mail. OCC staff review the multiple locations for the returned documentation and attach it to the relevant consult in a patient's electronic health record, which creates an alert notifying the ordering provider that the consult was completed.[21]

VHA does not require receipt of clinical documentation for closure of the community care consult. Although VHA expects OCC staff to work with community providers to ensure receipt of documentation for the patient's electronic health record, it allows OCC staff to close community care consults without documentation of the care provided. If OCC staff have not received medical record documentation from the non-VA provider after 14 days from the initial scheduled appointment, they will contact the patient to confirm attendance of the appointment and then attempt to retrieve the records of care provided.[22]

VHA requires OCC staff to make three attempts to retrieve medical documentation from the community provider and to document this in the electronic health record. They may close a consult after only one attempt but must make the subsequent attempts within 90 days.[23] If OCC

[17] VHA OCC, *Field Guidebook,* chap 3: "How to Perform Care Coordination."
[18] VHA OCC, *Field Guidebook,* chap 3.
[19] VHA OCC, *Field Guidebook,* chap 3.
[20] VHA OCC, *Field Guidebook,* chap 3.
[21] VHA OCC, *Field Guidebook,* chap 3 and chap 4: "Consult Completion and Medical Records Management."
[22] VHA OCC, *Field Guidebook*, chap 3 and chap 4.
[23] VHA OCC, *Field Guidebook,* chap 3 and chap 4.

staff are unable to obtain the medical documentation, they close the consult and note it as "administratively closed without documentation."[24] According to VHA OCC leaders, "administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation [are] expected to ensure continuity of care" even though OCC staff must close the consult within 90 days of the patient's appointment.[25]

[24] VHA OCC, *Field Guidebook,* chap 4.

[25] VHA OCC, *Field Guidebook,* chap 4.

Methodology

The OIG conducted a virtual inspection of VISN 7 from August 23 through September 2, 2021.[26] The inspection team examined operations during the study period of July 1, 2019, through June 30, 2020. During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

To determine compliance with VHA requirements, the OIG inspection team sampled electronic health records of patients who received care provided by VA and non-VA clinicians for each of the four focus areas reviewed. The team evaluated electronic health records and reviewed pertinent VISN administrative and performance measure data. The team also interviewed relevant VISN leaders and program managers and discussed oversight processes, validated electronic health record review findings, and inquired about reasons for noncompliance. In determining the quality of non-VA dialysis care, the OIG was unable to evaluate patients' electronic health records for compliance because the records lacked documentation from non-VA clinicians. As a result, the OIG interviewed available patients accepted by non-VA home dialysis programs to assess their perceptions of quality of care.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[27] 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.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the VISN leader completes corrective actions. The VISN 7 Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the VISN Director developed based on the reasons for noncompliance.

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

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[26] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization (WHO), March 11, 2020, accessed November 10, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. A pandemic is a disease outbreak over a wide geographic area that affects a significant proportion of the population. Merriam-Webster.com Dictionary, "pandemic," accessed November 10, 2020, https://www.merriam-webster.com/dictionary/pandemic. COVID-19 is caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)." "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," WHO, accessed November 10, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it.

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

Results and Recommendations

Care Coordination: Congestive Heart Failure Management

Congestive heart failure (CHF) is a condition that results when the heart is unable to effectively pump blood to meet physiologic needs. When blood does not circulate as it should, fluid can accumulate throughout the body.[28]

As a chronic disease, CHF is projected to affect more than 8 million people in the United States by 2030. Because CHF is a leading cause of VHA hospital admissions, VA has established evidence-based guidelines for its treatment with the goal of allowing veterans to live longer with a better quality of life.[29]

VHA primary care providers may refer patients with CHF to VA or non-VA cardiologists or heart failure clinics for management of their conditions. Monitoring a patient's daily weight, blood pressure, and heart function is important in managing the signs and symptoms of CHF.[30] VHA requires providers to document essential and relevant information, including their medication review and reconciliation, in the patient's electronic health record.[31] Additionally, medication reconciliation is a top patient safety priority and ensures patients and health care teams have an accurate list of medications at treatment transition points.[32]

To determine whether providers complied with selected requirements for care coordination for patients with CHF, the inspection team reviewed 96 randomly selected electronic health records of patients who had at least two primary care visits at a VISN 7 CBOC during the study period and were diagnosed with CHF at least one year prior to the study period.

The OIG evaluated selected components of care coordination for patients with CHF:

- Post-discharge contact following a VHA inpatient stay
- Use of alternative care modalities[33]

[28] "Heart Failure," National Heart, Lung, and Blood Institute, accessed September 23, 2020, https://www.nhlbi.nih.gov/health-topics/heart-failure.

[29] "Managing Heart Failure in Primary Care," VA Pharmacy Benefits Management (PBM) Academic Detailing Service, accessed July 7, 2021, https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/HeartFailure_Provider_ProviderGuide_IB101161.pdf; "Heart Failure," National Heart, Lung, and Blood Institute.

[30] "Managing Heart Failure in Primary Care," VA PBM Academic Detailing Service.

[31] VHA Directive 1164, *Essential Medication Information Standards,* June 26, 2015.

[32] "Medication Reconciliation to Prevent Adverse Drug Events," Institute for Healthcare Improvement, accessed September 23, 2020, https://www.ihi.org/topics/ADEsMedicationReconciliation/Pages/default.aspx.

[33] Alternative care modalities include coordinated care home telehealth and home-based primary care.

- Medication reconciliation
- Patient education on home care and monitoring[34]
- Monitoring and interventions for hypertension
- Referrals to non-VA providers for specialty care
- Communication of results to the ordering provider

Care Coordination Findings and Recommendations

VISN 7 CBOC providers delivered care that generally met the requirements listed above. The OIG made no recommendations.

[34] Examples of home care and monitoring include measuring daily weights, avoiding fluid overload, and restricting fluid and sodium intake. "Managing Heart Failure in Primary Care," VA PBM Academic Detailing Service; "Heart Failure," National Heart, Lung, and Blood Institute.

Primary and Mental Health Care: Diagnostic Evaluations

Patient aligned care team (primary care) staff screen veterans for various "conditions or risky health behaviors" such as cancer, tobacco and alcohol use, immunization status, suicide risk, and depression.[35] They conduct health education and refer patients to specialty care when clinically indicated.[36] Comprehensive primary care ensures veterans have access to the health care they need to maintain or improve their quality of life.[37] Clinical preventive services are part of comprehensive primary care and are used for early recognition of disease in persons without symptoms to prevent or reduce risks of illness or death.[38]

Diagnostic Evaluation of Patients at Risk for Depression

Depression is "one of the most common mental disorders in the United States" and can cause sadness, loss of energy or interest in activities, withdrawal from interactions with other people, feelings of hopelessness, and thoughts of suicide.[39] VHA requires annual depression screenings for patients receiving primary or mental health care.[40] At the time of this OIG inspection, VHA required staff to complete a suicide risk screening when a patient's depression screen was positive.[41] If either screening was positive, VHA required a provider to follow up with a diagnostic evaluation and refer the patient to a specialty or mental health care provider, if warranted.[42]

To determine if providers complied with selected requirements for diagnostic evaluations for positive depression screenings, the OIG team reviewed 100 randomly selected electronic health records of VISN 7 CBOC patients who screened positive for depression.[43] The OIG evaluated selected components required for positive depression screenings:

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[35] VHA Handbook 1101.10(1).

[36] VHA Handbook 1101.10(1).

[37] VHA Handbook 1101.10(1).

[38] VHA Handbook 1101.10(1).

[39] "VA Research on Depression," VA Office of Research & Development, September 2016, accessed September 1, 2021, https://www.research.va.gov/pubs/docs/va_factsheets/Depression.pdf.

[40] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder,* version 3.0, April 2016.

[41] VA Product Development, *Veterans Health Information Systems and Technology Architecture (VistA) Clinical Reminders, MH Reminder Updates, Installation and Setup Guide*, February 2017.

[42] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder,* version 3.0; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[43] These patients had screened positive (score of >3) on the depression screening tool (Patient Health Questionnaire-2, PHQ-2) at any CBOC in VISN 7 during a primary care visit occurring between July 1, 2019, through June 30, 2020, and did not have a positive depression screening in the prior three years from the positive screen date. Patients who were not veterans were excluded. Primary care visits are those with stop codes of 323 or 338. If a patient had more than one positive screen during the study period, the first occurrence was used for the review.

- Primary care providers conducted diagnostic evaluations in response to positive depression screenings.
- Primary care providers conducted suicide risk evaluations if suicide risk screenings were positive.
- Patients referred to specialty or mental health care providers had completed appointments within 30 days.[44]

Diagnostic Evaluation of Patients at Risk for Alcohol Use Disorder

Excessive drinking is associated with multiple health problems including chronic diseases, unintentional injuries, various other disorders, as well as homicide and suicide.[45] VHA requires alcohol use disorder screening for new patients and annual screenings for established patients.[46] If a patient's screening is positive and they are identified as being at risk for alcohol use disorder, VHA requires the provider to conduct a diagnostic evaluation and ensure the provision of education or counseling.[47]

To determine whether VISN 7 CBOC providers complied with selected requirements for diagnostic evaluations for positive alcohol use disorder screenings, the OIG team reviewed 96 randomly selected electronic health records of patients who screened positive for alcohol use disorder.[48] The OIG team evaluated selected components required for positive alcohol use disorder screenings:

- Primary care providers completed diagnostic evaluations in response to positive screenings.
- Diagnostic evaluations included education and counseling regarding drinking limits and the adverse consequences of heavy drinking.

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[44] VHA Directive 1230(2*), Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020; VHA Handbook 1160.01; VA Product Development, *Veterans Health Information Systems and Technology Architecture (VistA) Clinical Reminders, MH Reminder Updates, Installation and Setup Guide*, February 2017; *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 3.0.

[45] "Alcohol Questions and Answers," Centers for Disease Control and Prevention, accessed August 26, 2020, https://www.cdc.gov/alcohol/faqs.htm.

[46] VHA Handbook 1160.01.

[47] VHA Handbook 1160.01.

[48] These patients had screened positive (score of ≥5) on AUDIT-C (Alcohol Use Disorders Identification Test) at any CBOC in VISN 7 during a primary care visit occurring between July 1, 2019, through June 30, 2020, and did not have a positive alcohol use disorder screening in the prior three years from the positive screen date. Patients who were not veterans were excluded. Primary care visits are those with stop codes of 323 or 338. If a patient had more than one positive screen during the study period, the first occurrence was used for the review.

- Patients referred to specialty or mental health care providers had appointments scheduled within 30 days.[49]

Primary and Mental Health Care: Diagnostic Evaluations Findings and Recommendations

The OIG found that CBOC primary care providers completed diagnostic evaluations of patients at risk for depression or suicide, and patients referred for care by VA or non-VA specialty or mental health care providers had appointments scheduled within the required time frame. The OIG did not identify deficiencies regarding follow-up care for positive depression screening. The OIG also found that VISN 7 CBOC providers completed diagnostic evaluations of patients who were at risk for alcohol use disorder and generally met the requirements listed above. The OIG made no recommendations.

[49] VHA Handbook 1160.01.

Quality of Care: Home Dialysis Care

Home dialysis provided by VHA offers advantages over in-center (VA and non-VA) dialysis, including increased ability to deliver care to veterans with end-stage renal disease, especially when patients live far from VA medical centers. In addition, patients may experience improved quality of life with "greater survival and fewer hospitalizations," and costs may be lower than contracted dialysis service.[50] All VHA dialysis programs must offer home dialysis to medically qualified patients with end-stage renal disease.[51] Additionally, VHA requires

> VISN directors [to] convene a VISN Dialysis Council…with Dialysis Program representation from each VA medical facility in the VISN for the purpose of promoting efficient, high quality dialysis care within the VISN, coordinating the VISN operations of dialysis initiatives, harmonizing dialysis care within VISNs, and enhancing communication related to dialysis to/from VA facilities, non-VA dialysis facilities, VISN leadership, and the VHA National Kidney Program.[52]

VHA also requires all dialysis outpatients to be seen at least monthly by a clinician who provides end-stage renal disease care, evidenced by a monthly progress note "endorsed by the responsible independent renal practitioner."[53] A VHA home dialysis program must provide the following services:

- Patient training performed by a dialysis registered nurse
- Patient monitoring (patient's self-monitored data and a clinical exam) at least every two months
- Ongoing medical, nursing, nutritional, and social work support services, as needed
- Initial and periodic (at least annual) home visits[54]
- Provision of all necessary disposable supplies and dialysis devices approved by the U.S. Food and Drug Administration
- Regular monitoring of water quality in the case of home hemodialysis[55]

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[50] Areef Ishani et al., *Comparative Effectiveness of Home-based Kidney Dialysis versus In-center or Other Outpatient Kidney Dialysis Locations - A Systematic Review*, Department of Veterans Affairs Health Services Research & Development Service, Evidence Based Synthesis Program, April 2015.

[51] VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

[52] VHA Handbook 1042.01.

[53] The clinician should be "a physician, nurse practitioner, clinical nurse specialist, or physician's assistant." VHA Handbook 1042.01.

[54] VHA requires home visits prior to a patient's acceptance into the home dialysis program (initial) and then at least annually to assess the environmental safety in patients' homes and their adjustment to home dialysis. VHA Handbook 1042.01.

[55] VHA Handbook 1042.01.

VHA does not require non-VA dialysis providers to submit documentation of ongoing care. The VHA National Program Director for Kidney Disease and Dialysis described that the Centers for Medicare & Medicaid Services (CMS) established the requirements for non-VA dialysis care, and VHA does not require that non-VA dialysis providers send their medical documentation to VA. However, the National Program Director also stated that VHA providers can request it, for example, in response to a patient's complaint about his or her non-VA dialysis care.

VISN 7 did not have a home dialysis program, and VA providers referred patients to non-VA providers for care management. The OIG team reviewed electronic health records of all 99 VISN patients managed by non-VA dialysis providers during the study period but was unable to determine the quality of dialysis care because the records lacked documentation from the non-VA providers. As a result, the OIG team interviewed 41 home dialysis patients to assess their perceptions of the quality of their care.

Quality of Care Findings and Recommendations

During interviews, patients reported that home dialysis training, monitoring, and most support services provided by programs managed by non-VA providers generally met VHA's level of care requirements. However, the OIG found that home dialysis patients did not consistently report receiving initial and annual home visits, and VISN 7 staff could not monitor the quality of contracted home dialysis services because they did not have relevant documentation from the non-VA providers. Table 1 presents the OIG's findings related to patients' reports of the quality of home dialysis care provided by non-VA providers.

Table 1. Non-VA Program Compliance with Home Dialysis Requirements*

Requirement	Non-VA Care†
Training by a registered nurse	41 of 41 patients (100 percent) confirmed training by a registered nurse
Review of patient's self-monitoring data at least every two months	41 of 41 patients (100 percent) reported their self-monitoring data were reviewed at least every two months
Clinical support when needed	40 of 41 patients (98 percent) reported receiving support services when they needed it
Home visit–prior to acceptance into the home dialysis program‡	36 of 41 patients (88 percent) reported receiving an initial home visit
Home visit–annual§	32 of 41 patients (78 percent) reported receiving a home visit at least annually
Provision of supplies and equipment	41 of 41 patients (100 percent) reported provision of supplies and equipment by the non-VA home dialysis program without issues

Source: VA OIG.

**VISN 7 did not have a home dialysis program.*
†*The OIG determined these results based on patient interviews because there was no non-VA provider documentation available in the electronic health records. In interviews, the OIG did not restrict patients' responses to the study period of July 1, 2019, through June 30, 2020.*
‡*The OIG evaluated these visits for patients accepted into non-VA home dialysis programs during the study period.*
§*The OIG evaluated these visits for patients in non-VA home dialysis programs for a time period long enough to require an annual visit.*

When VHA facilities cannot offer home dialysis services due to geographic inaccessibility or lack of a VHA home dialysis program, providers must offer veterans access to home dialysis through non-VA providers.[56] VA is then responsible for monitoring the contracted dialysis services.[57]

The OIG found that 5 of 41 patients (12 percent) contacted by phone did not report receiving a home visit prior to the initiation of home dialysis, and 9 of 41 patients (22 percent) did not report receiving annual home visits. The OIG team discussed the lack of documentation of ongoing, routine care provided by non-VA dialysis providers with VISN leaders. The leaders acknowledged this and attributed it to processes established through dialysis contractual agreements.

[56] VHA Handbook 1042.01.
[57] VHA Handbook 1042.01.

Because VA does not require non-VA providers to forward documentation of care provided, VISN leaders, providers, and program staff could not monitor the quality of that care.[58] The OIG determined that clinicians at VISN 7 facilities referred patients to non-VA home dialysis programs without internal processes to monitor the quality of the clinical services.

Recommendation 1

1. The VISN 7 Director ensures VISN leaders, providers, and program staff monitor the quality of contracted clinical services for patients receiving non-VA home dialysis services.

VISN 7 concurred.

Target date for completion: June 30, 2023

VISN 7 response: VISN 7 Hemodialysis Council will develop a reporting tool to monitor the quality of contracted clinical services for patients receiving Community Care home dialysis services. Monitoring will be accomplished by audit of medical records of Veterans receiving home dialysis through community providers.

VISN 7 will initiate an audit of the medical records of all Veterans who were new to home dialysis provided by community providers (vendors) between January 1, 2022, and December 31, 2022. The audits will assess if those Veterans received an initial home visit from the vendor prior to initiation of home dialysis services (target = 100% compliance with this requirement).

Additionally, a sample (20%) of Veterans who have been receiving on going home dialysis from community providers for greater than two years (as of December 31, 2022) will have their medical records audited to ensure that they have received an annual home visit from the vendor in the prior 12-16 months (target for compliance = 100%).

Auditing for compliance with the requirement of initial and annual home visits by the vendors will occur as an ongoing performance monitor conducted by VISN 7. Audits will continue quarterly until compliance is met for two consecutive quarters and then will occur annually. All audits will be completed within 90 days of the end of the audit period to allow for time to obtain outside records. Data will be reported at the quarterly VISN Hemodialysis Council meeting and the VISN Specialty Care ICC [Integrated Clinical Community]. The VISN specialty care lead will communicate audit results to the VISN Healthcare Delivery Council and appropriate contracting officials within VHA who are responsible for the National Dialysis Service Contracts.

[58] VHA Handbook 1042.01.

Women's Health: Mammography Services and Communication of Results

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment in all VA medical facilities. Every care site in the VA healthcare system must provide women's health services; however, not every site provides mammography services.[59] For these locations, VA clinicians refer patients to non-VA mammography providers.

VHA established timeliness requirements applicable to VA and non-VA providers regarding notification of mammography results to ordering providers and patients. Specifically, when a mammogram result is negative (normal), the imaging provider must communicate the result to the ordering provider in writing within 30 days of the procedure.[60] VHA then requires the ordering provider (or designee) to "communicate the results of normal mammograms completed in-house or through contract or non-VA care to the patient within 14-calendar days of receiving the results."[61]

Reports of positive (abnormal) mammography results should include a recommended course of action and must be communicated to the ordering provider as soon as possible (defined by VHA as being no more than 7 calendar days), followed by a written report within 30 days of the procedure date. The ordering provider must then communicate abnormal results to the patient within 7 calendar days from the date of receipt.[62] VHA requires the ordering provider to document the communication of the mammography results to the patient in the electronic health record.[63]

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[59] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017, amended July 24, 2018, and further amended on June 29, 2020, as VHA Directive 1330.01(3). (This directive was in effect during the period for documents reviewed in this report (July 1, 2019, through June 30, 2020). The directive was further amended on January 8, 2021, as VHA Directive 1330.01(4); on August 25, 2022, as VHA Directive 1330.01(5); and again on September 9, 2022, as VHA Directive 1330.01(6)).

[60] VHA Directive 1330.01(2).

[61] For this report, a negative result is a normal result. VHA Directive 1330.01(2).

[62] According to the Food and Drug Administration, a "positive mammogram" refers to a mammogram with an overall assessment of findings that are either "suspicious" or "highly suggestive of malignancy." "Mammography Quality Standards Act Regulations," Food and Drug Administration, accessed July 6, 2021, https://www.fda.gov/radiation-emitting-products/regulations-mqsa/mammography-quality-standards-act-regulations. In this report, a positive result is considered an abnormal result. VHA Directive 1105.03, *Mammography Program Procedures and Standards,* May 21, 2018; VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. (This directive was in effect during the period for documents reviewed in this report (July 1, 2019, through June 30, 2020). It was amended on January 24, 2022, to VHA Directive 1088(1). The two directives contain the same language regarding communication of abnormal results to patients within 7 calendar days.)

[63] VHA Directive 1088; VHA Directive 1105.03.

To determine compliance with VHA requirements, the OIG team reviewed the electronic health record for 89 randomly selected patients who received non-VA mammography referrals and had the procedures performed from July 1, 2019, through June 30, 2020. The OIG evaluated the following requirements:

- Completeness of mammography reports
  - Patient name and identifier
  - Non-VA provider name with signature
  - Procedure date
  - Recommendations for further action and follow-up if indicated
- Linking of mammography reports in the electronic health record[64]
- Communication of normal or abnormal results within required time frames[65]

Women's Health Findings and Recommendations

The OIG found that community-based mammography results were complete and linked to orders in the patient's electronic health record, and ordering providers received mammogram results within the 30-day requirement. However, the OIG found that ordering providers did not document communication of normal mammogram results to patients within the required time frame.

VHA requires the ordering provider (or designee) to "communicate the results of normal mammograms completed in-house or through contract or non-VA care to the patient within 14-calendar days of receiving a normal result."[66] Based on the electronic health records reviewed, the OIG estimated that providers did not communicate normal results within the 14-day time frame to 24 (95% CI: 14.20 to 33.77) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[67] Communication to the patient

[64] "If reports are received on paper, they must be scanned into VistA [Veterans Health Information Systems and Technology Architecture] Imaging and linked to an administrative report in VistA/CPRS [Computerized Patient Record System]. Patient reports must be incorporated into VistA either by software modifications or by scanning a copy of the paper report into VistA Imaging and associating it with an order for an outside radiology procedure in CPRS." For this report, the OIG considered the term *linking* to be associating the report with an order for an outside radiology procedure to incorporate it into the patient's VHA electronic health record by scanning a hard copy or using software modifications. VHA Directive 1105.03.

[65] VHA Directive 1105.03; VHA Directive 1330.01(2); VHA Directive 1330.01(3); VHA Directive 1088.

[66] For this report, a negative result is a normal result. VHA Directive 1330.01(2).

[67] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

regarding normal results ranged from 1 to 74 days following testing. When patients do not receive timely mammography results, they may not know whether additional follow-up care is needed. VISN leaders stated that they reviewed communication timeliness during their visits to facilities and did not feel there were systemic problems with delays in communication of test results. They attributed delays to a few noncompliant providers and claimed that non-VA mammography providers gave patients their results directly; patients then communicated the results to the ordering provider.

Recommendation 2

2. The VISN 7 Director ensures that ordering providers communicate normal mammography results to patients within 14 calendar days.

VISN 7 concurred.

Target date for completion: June 30, 2023

VISN 7 response: A VISN wide Mammogram collaborative was initiated November 2021 after review and discussion of OIG's preliminary findings. One of the goals identified in the collaborative was to ensure compliance with the 14-day notification requirement for normal testing results. Audits of patient notifications are being completed. The results of audits for normal test result notifications will be reviewed and reported in Healthcare Quality Safety Value Committee for 6 months to monitor compliance of patient notifications. Reporting requirements will continue until each facility is able to demonstrate 90% compliance for 3 months is sustained.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities and simultaneously providing contracted care in the community, especially during times of unprecedented stress on the U.S. healthcare system. The OIG conducted this review of the VISN 7: VA Southeast Network, which is responsible for the oversight of the care provided by its associated medical facilities, CBOCs, and contracted providers.

To assist VISN leaders in evaluating the quality of care provided to veterans in the community within their jurisdiction, the OIG conducted a detailed review of four clinical and administrative areas and issued two recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations do not reflect the caliber of services delivered in the community by VA and non-VA providers, they illuminate areas of concern and help guide improvement efforts. A summary of the OIG's recommendations is presented in appendix A.

Appendix A: Care in the Community Recommendations

The table below outlines two OIG recommendations attributable to the VISN Director. The intent is for the VISN Director and other leaders to use the recommendations to help improve operations and clinical care. The recommendations address systems' issues that may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of OIG Recommendations

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Congestive Heart Failure	• Post-discharge contact following a VHA inpatient stay • Alternative care modalities • Medication reconciliation • Patient education on home care and monitoring • Hypertension monitoring and interventions • Referrals to non-VA specialty care providers • Communication of results to the ordering provider	• None	• None
Primary and Mental Health Care: Diagnostic Evaluations	• Diagnostic evaluations in response to positive depression or alcohol use disorder screenings • Diagnostic evaluations include all required elements • Timeliness of scheduled and completed specialty or mental health care appointments	• None	• None

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality of Care: Home Dialysis Care	• Patient training • Periodic patient monitoring • Support services included required elements • Monitoring of contracted home dialysis service	• VISN leaders, providers, and program staff monitor the quality of contracted clinical services for patients receiving non-VA home dialysis services.	• None
Women's Health: Mammography Services and Communication of Results	• Completeness of mammography reports • Linking of mammography reports to orders in the electronic health record • Communication of normal or abnormal results within required time frames	• Ordering providers communicate normal mammography results to patients within 14 calendar days.	• None

Source: VA OIG.

Appendix B: VA Outpatient Clinic Profiles

Table B.1. provides information relative to each of the clinics.[1]

Table B.1. VA Outpatient Clinic Classification, Workload/Encounters, and Community Care Referrals (July 1, 2019, through June 30, 2020)

Location	Station No.	VHA Site Tracking Classification	Rural Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Flowery Branch, GA	508GE	Multi-Specialty CBOC	Urban	52,616	4,250
Austell, GA	508GF	Primary Care CBOC	Urban	31,390	2,064
Stockbridge, GA	508GG	Primary Care CBOC	Urban	44,114	3,137
Lawrenceville, GA	508GH	Multi-Specialty CBOC	Urban	49,626	3,109
Newnan, GA	508GI	Multi-Specialty CBOC	Urban	30,123	1,973
Blairsville, GA	508GJ	Multi-Specialty CBOC	Rural	18,355	2,025
Decatur, GA (Rome)	508GL	Primary Care CBOC	Urban	13,556	2,187
Marietta, GA	508GO	Primary Care CBOC	Urban	16,701	1,801
Decatur, GA (Gwinnett)	508QE	Primary Care CBOC	Urban	22,466	1,099
Decatur, GA (Atlanta)	508QF	Multi-Specialty CBOC	Urban	183,823	11,263
Athens, GA	509GA	Primary Care CBOC	Urban	29,981	4,301
Aiken, SC	509GB	Primary Care CBOC	Urban	24,698	2,063
Augusta, GA (Ray Hendrix)	509QA	Primary Care CBOC	Rural	7,128	1,844

[1] Table B.1. includes all outpatient clinics in the community that were in operation as of July 1, 2019. An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition." VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

Location	Station No.	VHA Site Tracking Classification	Rural Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Huntsville, AL	521GA	Multi-Specialty CBOC	Urban	122,811	7,455
Sheffield, AL	521GC	Primary Care CBOC	Urban	25,124	2,071
Gadsden, AL (Rainbow City)	521GD	Primary Care CBOC	Urban	15,479	1,489
Oxford, AL	521GE	Primary Care CBOC	Urban	25,850	818
Jasper, AL	521GF	Primary Care CBOC	Rural	14,576	253
Bessemer, AL	521GG	Primary Care CBOC	Urban	22,938	46
Childersburg, AL	521GH	Primary Care CBOC	Rural	14,122	389
Guntersville, AL	521GI	Multi-Specialty CBOC	Rural	27,228	1,943
Birmingham, AL	521GJ	Multi-Specialty CBOC	Urban	109,360	2,046
Savannah, GA	534BY	Multi-Specialty CBOC	Urban	146,851	6,340
Myrtle Beach, SC	534GB	Multi-Specialty CBOC	Urban	67,473	6,415
Beaufort, SC	534GC	Multi-Specialty CBOC	Rural	32,999	1,131
Goose Creek, SC	534GD	Multi-Specialty CBOC	Urban	71,135	2,186
Hinesville, GA	534GE	Multi-Specialty CBOC	Urban	62,650	2,627
Charleston, SC	534QA	Multi-Specialty CBOC	Urban	57,043	1,414
Greenville, SC	544BZ	Multi-Specialty CBOC	Urban	130,855	7,730
Florence, SC	544GB	Primary Care CBOC	Urban	44,351	1,334
Rock Hill, SC	544GC	Primary Care CBOC	Urban	32,588	1,515
Anderson, SC	544GD	Multi-Specialty CBOC	Urban	49,089	3,332

Location	Station No.	VHA Site Tracking Classification	Rural Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Orangeburg, SC	544GE	Primary Care CBOC	Rural	30,169	553
Sumter, SC	544GF	Primary Care CBOC	Urban	33,214	590
Spartanburg, SC	544GG	Primary Care CBOC	Urban	26,394	1,559
Macon, GA	557GA	Multi-Specialty CBOC	Urban	53,851	7,055
Albany, GA	557GB	Multi-Specialty CBOC	Rural	31,579	4,398
Milledgeville, GA	557GC	Primary Care CBOC	Rural	9,855	835
Brunswick, GA	557GE	Multi-Specialty CBOC	Urban	20,796	5,437
Tifton, GA	557GF	Primary Care CBOC	Rural	17,645	3,951
Dublin, GA (Perry)	557HA	Primary Care CBOC	Urban	17,233	2,341
Columbus, GA	619GA	Multi-Specialty CBOC	Urban	31,513	5,975
Fort Rucker, AL (Wiregrass)	619GD	Multi-Specialty CBOC	Rural	29,545	7,037
Monroeville, AL (Monroe County)	619GE	Primary Care CBOC	Rural	3,859	1,934
Montgomery, AL	619GF	Multi-Specialty CBOC	Urban	71,200	14,675
Fort Benning, GA	619QB	Primary Care CBOC	Urban	36,053	10,104
Selma, AL	679GA	Primary Care CBOC	Rural	6,499	665

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

Appendix C: Expenditures for Community Care

Table C.1. Community Care Expenditures by Fiscal Year for VHA, VISN 7, and VISN 7 Facilities

Location	Fiscal Year 2018	Fiscal Year 2019	Fiscal Year 2020	Fiscal Year 2021
VHA	$7,864,960,843.79	$11,337,791,663.67	$4,181,333,650.39	$4,186,505,407.31
VISN 7*	$458,586,851.85	$648,139,528.44	$256,685,389.36	$286,044,946.47
Atlanta, GA (508/00)	$87,399,894.71	$133,101,597.24	$57,996,309.93	$69,860,535.44
Augusta, GA (509/00)	$37,019,626.36	$64,828,475.48	$24,032,963.01	$37,034,516.32
Birmingham, AL (521/00)	$56,022,726.14	$75,196,761.86	$24,367,211.30	$27,407,290.28
Charleston, SC (534/00)	$59,302,977.99	$77,187,341.59	$33,816,556.56	$32,537,797.99
Columbia, SC (544/00)	$79,012,149.50	$108,694,102.90	$58,509,687.59	$54,644,612.47
Dublin, GA (557/00)	$55,820,613.92	$77,101,809.59	$27,631,882.18	$28,790,234.29
Central AL† (619/00)	$64,622,100.90	$85,171,642.19	$23,076,498.92	$28,035,604.24
Tuscaloosa, AL (679/00)	$19,386,762.33	$26,857,797.59	$7,254,279.87	$7,734,355.44

Source: VHA community care expenditure data.

Note: The OIG did not verify the accuracy of this VHA disbursement information.

**Expenditures include CBOCs and outpatient clinics associated with VA medical facilities.*

†*Includes the Montgomery and Tuskegee campuses.*

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 14, 2022

From: Director, VA Southeast Network (10N7)

Subj: Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)

To: Director, Office of Healthcare Inspections (54CC00)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

On behalf of VA Southeast Network, we would like to express our gratitude to the Office of Inspector General Team for their review. I have reviewed the draft report and all recommendations for "Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)". I concur with the 2 recommendations and action plans. We appreciate the opportunity to improve the oversight we provide here at VA Southeast Network.

For additional questions, contact the please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA
Network Director
VA Southeast Network (VISN 7) (10N7)

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