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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore

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Figure 1. Baltimore VA Medical Center of the VA Maryland Health Care System.
Source: <https://www.va.gov/maryland-health-care/> (accessed January 25, 2024).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Maryland Health Care System, which includes the Baltimore VA Medical Center (central Baltimore), Loch Raven VA Medical Center (northern Baltimore), Perry Point VA Medical Center (Perry Point), and multiple outpatient clinics in Maryland. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure 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. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the VA Maryland Health Care System during the week of August 7, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued five recommendations to the Deputy Medical Center Director, Chief of Staff, Associate Director, and Assistant Director in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national

policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 22.

VA Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 25-26, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 2 and 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report’s evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Maryland Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.¹

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.² Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”³

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:⁴

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

² Anam Parand et al., “The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review,” *British Medical Journal* 4, no. 9 (September 5, 2014): 13, <https://doi.org/10.1136/bmjopen-2014-005055>.

³ Danae F. Sfantou et al., “Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

⁴ CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years’ focus areas.

Methodology

The VA Maryland Health Care System includes the Baltimore VA Medical Center (central Baltimore), Loch Raven VA Medical Center (northern Baltimore), Perry Point VA Medical Center (Perry Point), and multiple outpatient clinics in Maryland. General information about the healthcare system can be found in appendix B.

The OIG inspected the healthcare system during the week of August 7, 2023.⁵ During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁶ 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 healthcare system leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders 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.

⁵ The OIG's last comprehensive healthcare inspection of the VA Maryland Health Care System occurred in August 2021. There were no Joint Commission reviews performed in FY 2022.

⁶ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.⁷ High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their organization’s vision and strategy, and “practice systems thinking and collaboration across boundaries.”⁸ When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.⁹

To assess this healthcare system’s leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders’ responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Medical Center Director (Director), Deputy Medical Center Director (Deputy Director), Chief of Staff, Associate Director for Patient Care Services, Associate Director, Assistant Director, and Chief Quality Officer. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately one year, although the Director had been in the role since 2020, and the Chief of Staff had served for more than seven years. To help assess executive leaders’ engagement, the OIG interviewed the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services,

⁷ Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

⁸ Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

⁹ Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

Associate Director, Assistant Director, and Chief Quality Officer regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of \$882,612,513 had increased by approximately 6 percent compared to the previous year's budget of \$836,242,640.¹⁰ The Deputy Director reported using these funds to recruit new staff members and retain existing ones by providing incentives such as educational benefits and special salary rates. The Director highlighted recruitment of nearly 100 personnel to schedule and coordinate community care for veterans.¹¹ The Associate Director added that leaders applied some of the funds to replace equipment including beds, vital sign monitors, and stretchers, as well as upgrade to newer technology in the interventional radiology department.¹²

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹³ Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.¹⁴ Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's scores remained consistent over all three years and were slightly lower than VHA's in FYs 2021 and 2022, indicating staff felt about as comfortable disclosing suspected violations as VHA employees nationally. To increase staff comfort with reporting issues, the Associate Director said leaders focused on psychological safety and the importance of

¹⁰ Veterans Health Administration (VHA) Support Service Center.

¹¹ "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed September 21, 2023, <https://www.va.gov/communitycare/>.

¹² The interventional radiology department performs minimally invasive procedures using radiologic modalities. "What is Vascular and Interventional Radiology," Johns Hopkins Medicine, accessed January 11, 2024, https://www.hopkinsmedicine.org/interventional-radiology/what_is_IR.html.

¹³ "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

¹⁴ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

employees raising concerns, while the Chief Quality Officer discussed providing education on high-reliability organizations.¹⁵

**Table 1. All Employee Survey Question:
Ability to Disclose a Suspected Violation
(FYs 2020 through 2022)**

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Maryland Health Care System	3.8	3.8	3.8

Source: VA All Employee Survey (accessed January 3, 2023).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients’ healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁶ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

In all three years and across inpatient, primary care, and specialty care settings, the system’s scores were lower than those of VHA. Additionally, inpatient and primary care scores trended downward all three years, indicating patients were increasingly less satisfied with their experiences. The Director pointed to staffing challenges among acute care medicine nurses and an inadequate focus on patient satisfaction as factors driving low inpatient scores. The Associate Director for Patient Care Services reported meeting with patients to understand their concerns and addressing patient complaints expressed on social media. For primary and specialty care, the Chief of Staff indicated position vacancies and telephone access issues as reasons for lower patient satisfaction. The Chief of Staff discussed working with the VISN hiring office to assist with backfilling positions and having dedicated staff to answer phone lines.

¹⁵ “A high-reliability organization (HRO) is an organization with a goal of achieving ‘zero harm’ in an environment where accidents are expected due to complexity or risk factors.” VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

¹⁶ “Patient Experiences Survey Results,” VHA Support Service Center.

**Table 2. Survey of Healthcare Experiences of Patients
(FYs 2020 through 2022)**

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	58.3	69.7	58.1	68.9	57.9
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	82.2	81.9	80.3	81.7	79.2
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	84.6	83.3	76.7	83.1	80.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

*The response average is the percent of “Definitely yes” responses.

†The response average is the percent of “Very satisfied” and “Satisfied” responses.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders’ Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁷ According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.¹⁸ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁷ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁸ The Joint Commission, *Standards Manual*, E-edition, July 1, 2023. A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.¹⁹

“A sentinel event is a patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”²⁰

Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”²¹ Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”²² To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²³

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022. Risk management staff reported there were 14 sentinel events, none of which resulted in death; 27 institutional disclosures; and 0 large-scale disclosures that occurred during this time frame.

The Chief of Staff described completing institutional disclosures and meeting weekly with risk management and quality management staff to review cases. The Chief of Staff also said executive leaders receive daily copies of patient safety reports and providers conduct clinical disclosures when relevant events occur.²⁴ The Director discussed reviewing patient safety reports and tracking the ratio between near misses and patient safety events to identify trends.

¹⁹ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

²⁰ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission’s definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

²¹ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²² VHA Directive 1004.08.

²³ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

²⁴ “Clinical disclosure of adverse events is a process by which the patient’s clinician informs the patient or the patient’s personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient’s care.” VHA Directive 1004.08.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²⁵ To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²⁶ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²⁷

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.²⁸ According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.²⁹

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.³⁰ 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."³¹ Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.³²

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed three unanticipated deaths that occurred within 24 hours of inpatient admission during FY 2022. Additionally, the OIG requested a list of patient suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022, and staff reported no patients met those criteria.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

²⁵ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²⁶ VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²⁷ VHA Directive 1100.16.

²⁸ VHA Handbook 1050.01; VHA Directive 1050.01(1).

²⁹ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2023.

³⁰ 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. VHA Directive 1190.

³¹ VHA Directive 1190.

³² VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³³ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³⁴

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³⁵ LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³⁶

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.³⁷

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.³⁸ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

³³ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³⁴ VHA Handbook 1100.19.

³⁵ VHA Handbook 1100.19.

³⁶ VHA Handbook 1100.19.

³⁷ VHA Handbook 1100.19.

³⁸ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.³⁹

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to recommend continued privileges based, in part, on Ongoing Professional Practice Evaluation activities such as direct observation, chart reviews, and clinical discussions.⁴⁰ VHA also requires an executive committee of the medical staff to recommend continued privileges based on the evaluation results.⁴¹ The OIG found that service chiefs did not consistently demonstrate they recommended reprivileging based on evaluation activities. Consequently, the Medical Executive Committee did not reliably consider all evaluation results in their reprivileging recommendations.⁴² This may have resulted in LIPs continuing to deliver care without thorough reviews of their practices, which could negatively affect patient care and safety. The Manager of the Medical Staff Office attributed the noncompliance to lack of attention to detail.

Recommendation 1

1. The Chief of Staff ensures service chiefs recommend continued privileges for licensed independent practitioners based on Ongoing Professional Practice Evaluation activities, and the Medical Executive Committee recommends them based on evaluation results.

³⁹ Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

⁴⁰ VHA Handbook 1100.19; VHA Directive 1100.21(1).

⁴¹ VHA Handbook 1100.19; VHA Directive 1100.21(1).

⁴² The Medical Executive Committee is this system’s executive committee of the medical staff.

Healthcare system concurred.

Target date for completion: October 31, 2024

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Medical Executive Committee, known at the VA Maryland Health Care System (VAMHCS) as Executive Counsel of the Medical Staff (ECMS) - Professional Standards Board (PSB), reviews and considers Ongoing Professional Practice Evaluation (OPPE) results in their re-privileging determinations. During this review, the Chief of Staff/designee presents the OPPE and the service chief answers questions about OPPE. These reviews are reflected in the ECMS-PSB minutes and documented under each licensed independent practitioner (LIP) in VetPro. VetPro is VHA's mandatory credentialing software platform to document the credentialing of VHA health care providers.

The Medical Staff Office (MSO) implemented a new electronic process. Individual practitioner folders were created for each service on the Chief of Staff SharePoint, a centralized location, to upload standardized OPPE with five associated chart reviews for that practitioner. The service chief/designee will upload the OPPE and five chart reviews for that practitioner which includes service chief recommendations to continue privileges for licensed independent practitioners. This new process enables the MSO staff to track, audit, and present service recommendations based on evaluation results at ECMS-PSB during the re-credentialing periods.

Compliance will be monitored by the Quality Performance Improvement Specialist until a benchmark of 90 percent compliance for 6 consecutive months is met. The Quality Performance Improvement Specialist will report data during bi-monthly ECMS-PSB. The numerator will be the number of practitioners' OPPEs with evidence that the service chief's recommendation to continue current privileges was based on the results of OPPE activities and the ECMS-PSB's recommendation to continue current privileges was based on evaluation results. The denominator will be the number of practitioners' OPPEs that service chiefs and ECMS-PSB reviewed.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA’s environment of care program is to ensure “a safe, clean health care environment that provides the highest standards in the health care setting.”⁴³ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.⁴⁴

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.⁴⁵

During the OIG’s review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected the following patient care areas:

- Baltimore VA Medical Center
 - Emergency Department
 - Inpatient mental health unit (6A)
 - Medical intensive care unit
 - Medical/surgical inpatient unit (3 Medicine)
 - Primary care clinic
- Loch Raven VA Medical Center
 - Community-based outpatient clinic (LR CBOC)
 - Community living center (LR-2)

⁴³ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

⁴⁴ VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

⁴⁵ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

- Perry Point VA Medical Center
 - Community living centers (23A and 14A)
 - Primary care clinic
 - Urgent care clinic

Environment of Care Findings and Recommendations

The Occupational Safety and Health Administration requires staff to post hazard warning signs to identify rooms that contain actual or potential biohazardous agents.⁴⁶ The OIG observed that some soiled utility rooms lacked door signage to indicate storage of biohazardous materials.⁴⁷ Employee exposure to hazardous agents “can cause illness and impaired health and well-being, and can adversely affect VHA operations.”⁴⁸ The Chief of Safety and Occupational Health Service cited unawareness of the requirement and unwarranted removal of previously placed biohazard signs.

Recommendation 2

2. The Deputy Medical Center Director ensures staff post biohazard signs in applicable areas.⁴⁹

⁴⁶ 29 C.F.R. § 1910.145(e)(4).

⁴⁷ The OIG observed lack of biohazard signage in soiled utility rooms in the Emergency Department, primary care clinic, and inpatient mental health unit at the Baltimore VA Medical Center.

⁴⁸ VHA Directive 7702, *Industrial Hygiene Program and Exposure Assessment Process*, July 29, 2021.

⁴⁹ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Deputy Medical Center Director evaluated and determined no additional reasons for noncompliance. The Deputy Medical Center Director ensured staff posted biohazard signs in applicable areas. The Chief of Safety and Occupational Health Service reviewed Occupational Safety and Health Administration, Department of Veterans Affairs, and VA Maryland Healthcare System directives, policies, and procedures. The Chief of Safety and Occupational Services directed Life Safety Specialists secure biohazard signs on soiled utility rooms. Appropriate signage was confirmed on the soiled utility room doors of ED [Emergency Department] (1D-129), Inpatient Mental Health (6A-135), and Primary Care Clinic (1C-162) at the VAMHCS Baltimore Campus by September 30, 2023. The Quality Accreditation Specialist reported placement of biohazard signs on December 20, 2023, during Executive Quality and Patient Safety Committee, which is attended by the Deputy Medical Center Director/designee.

We would like to request closure for this recommendation based on supporting evidence provided to the OIG.

VHA requires staff at all medical facilities to provide a safe and clean healthcare environment.⁵⁰ The OIG observed dirty bottom shelves in two supply rooms. In addition, the OIG found dirty refrigerators in three food storage areas and dirty sinks in two. Lack of cleanliness increases the potential spread of infections. The Chief of Supply Chain Management said staff had difficulty cleaning bottom shelves due to how they were installed. In addition, the Emergency Department Nurse Manager and Chief of Environmental Service reported that environmental and nursing staff did not clean the refrigerators and sinks due to their lack of clarity regarding cleaning responsibilities and inattention to detail.

Recommendation 3

3. The Associate Director ensures staff keep patient care areas safe and clean.⁵¹

⁵⁰ VHA Directive 1608.

⁵¹ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Associate Director evaluated and determined no additional reasons for noncompliance. The Associate Director has ensured that staff have kept patient care areas safe and clean. An interdisciplinary team worked together to ensure that areas of deficiency were corrected and that the VA Maryland Health Care System (VAMHCS) continues to monitor safety and cleanliness. Areas of non-compliance (i.e., dirty closets, sinks, and refrigerators) were cleaned while surveyors were on site. The appropriate leadership reviewed cleaning schedules with their staff. Supply Chain Management Service (SCMS) maintains and monitors supply closet cleanliness. Environmental Management Services (EMS) maintains sink cleanliness. Nursing service maintains patient nutrition refrigerator cleanliness and monitors patient care areas.

Supply Closet cleaning documentation is recorded weekly by SCMS Supply Technicians and reported to the Chief and Deputy Chiefs of Supply Chain Management in a monthly report. Data collection for cleanliness was monitored by Quality Performance Improvement Specialist. Compliance is monitored by Quality Performance Improvement Specialist until a benchmark of greater than 90 percent satisfactory clean rating for six consecutive months. The numerator was the number of satisfactory ratings. The denominator was the total count of weekly documentation.

Cleanliness of patient care areas, including cleanliness of sinks and refrigerators, is monitored by nursing staff. Patient care area cleanliness, infection control measures, safety and security measures, and equipment and storage concerns were monitored with monthly Nursing Environment of Care Checklists. Nursing leadership submitted completed checklists to the Quality Accreditation Specialist for monitoring. Compliance was monitored by Quality Accreditation Specialist until a benchmark of greater than 90 percent satisfactory clean rating for six consecutive months. The numerator was the number of audit items that required inspection of sinks and refrigerators that were compliant. The denominator was the total number of audit items that required inspection of sinks and refrigerators.

Checklist compliance was reported by the Accreditation Specialist during quarterly Executive Quality and Patient Safety Committee meetings, which is attended by the Associate Director/designee. The ED and Inpatient Mental Health supply closets have met a compliance rate of greater than 90 percent for six consecutive months (August 2023 through February 2024). The ED, 3Medicine, and MICU [Medical Intensive Care Unit] sink and patient nutrition refrigerator audits have met a compliance rate of greater than 90% for six consecutive months (October 2023 through March 2024).

We would like to request closure for this recommendation based on supporting evidence provided to the OIG.

VHA requires staff to periodically test panic alarms in the inpatient mental health unit and document VA police response times.⁵² The OIG found no evidence staff documented police response times for panic alarm testing. If staff do not document response times, police may be unable change their processes, if needed, to ensure timely response to emergencies. The Chief of Police reported being unaware of the requirement.

Recommendation 4

4. The Assistant Director ensures staff document VA police response times for panic alarm testing in the inpatient mental health unit.

Healthcare system concurred.

Target date for completion: October 31, 2024

Healthcare system response: The Assistant Director evaluated and determined no additional reasons for noncompliance. The Assistant Director will monitor to ensure that staff document Police Service response times for panic alarm testing in the inpatient mental health unit. Panic alarm testing will include documentation of response times by Police Service. Police Service will monitor panic alarm testing response times monthly for the inpatient mental health unit until 90 percent compliance is met for six consecutive months. The numerator will be the number of required and completed panic alarm monthly tests with recorded police response times and the denominator will be the number of required and completed panic alarm monthly tests. Police Service will report compliance with panic alarm testing response time documentation to the Executive Council of Operations Services, which is attended by the Assistant Director/designee, monthly until 90 percent or greater compliance is met for six consecutive months.

⁵² VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, “Mental Health Environment of Care Checklist,” October 18, 2022.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁵³ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁵⁴ The suicide rate for veterans was higher than for nonveteran adults during 2020.⁵⁵ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁵⁶

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.⁵⁷ VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.⁵⁸

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.⁵⁹

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 48 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

⁵³ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁵⁴ “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed January 20, 2023.

⁵⁵ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁵⁶ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁵⁷ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

⁵⁸ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Suicide Behavior and Overdose Reporting,” July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Suicide Behavior and Overdose Reporting,” May 9, 2023.)

⁵⁹ VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. “Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA states that providers should complete the Comprehensive Suicide Risk Evaluation the same day following a positive suicide risk screen in all ambulatory care settings.⁶⁰ The OIG estimated that providers did not evaluate 42 (95% CI: 28 to 56) percent of patients for suicide risk using the Comprehensive Suicide Risk Evaluation template following a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.⁶¹ Failure to evaluate suicide risk following a positive screen could result in missed opportunities for providers to identify patients who are at imminent risk for suicide and intervene. The Director, Mental Health Clinical Center shared that primary care providers expressed concerns the evaluation required too much time to complete during a primary care visit, and they lacked the training to elicit meaningful responses from patients. One primary care provider reported appropriately addressing patient concerns by discussing suicide risk during visits and placing consults for mental health care.

Recommendation 5

5. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

⁶⁰ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

⁶¹ 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.

Healthcare system concurred.

Target date for completion: February 28, 2025

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff will monitor to ensure that providers complete the Comprehensive Suicide Risk Evaluation (CSRE) on the same day as a positive suicide risk screen in all ambulatory care settings.

Weekly review of CSRE completion data is done by Performance Management (PM) staff. Results from weekly reviews are aggregated into monthly reports by the Performance Management staff. These reports, including fall outs, are brought to Mental Health Clinical Center (MHCC) leadership and Ambulatory and Emergency Clinical Care Center (AECCC) leadership weekly so they may follow up and provide re-education as needed as well as complete the missed CSRE.

Weekly reviews and monthly aggregated CSRE reports will continue until 90 percent compliance is achieved for 6 consecutive months. Suicide Prevention Coordinators report data monthly to the Executive Quality and Patient Safety Committee (EQPSC) meetings, which is attended by the Chief of Staff/designee. The numerator will be the number of completed Comprehensive Suicide Risk Evaluations on the same day as a patient's positive suicide risk screen in all ambulatory settings. The denominator will be the number of electronic health records with a positive Columbia Suicide Severity Rating Scale screen in all ambulatory settings.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided five recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this healthcare system. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Deputy Medical Center Director, Chief of Staff, Associate Director, and Assistant Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • None
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • Service chiefs recommend continued privileges for licensed independent practitioners based on Ongoing Professional Practice Evaluation activities, and the Medical Executive Committee recommends them based on evaluation results.
Environment of Care	<ul style="list-style-type: none"> • Staff post biohazard signs in applicable areas. • Staff keep patient care areas safe and clean. • Staff document VA police response times for panic alarm testing in the inpatient mental health unit.
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> • Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 5.¹

**Table B.1. Profile for VA Maryland Health Care System (512)
(October 1, 2019, through September 30, 2022)**

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	\$743,655,430	\$836,242,640	\$882,612,513
Number of:			
• Unique patients	53,110	58,441	57,247
• Outpatient visits	636,512	737,910	665,190
• Unique employees§	2,976	2,919	2,897
Type and number of operating beds:			
• Community living center	275	275	275
• Domiciliary	150	150	143
• Medicine	69	69	69
• Mental health	10	10	11
• Residential psychiatry	23	23	23
• Surgery	33	33	33
Average daily census:			
• Community living center	178	134	139
• Domiciliary	75	63	72
• Medicine	45	46	46
• Mental health	5	3	4
• Residential psychiatry	13	8	8

¹ VHA medical facilities are classified according to a complexity model; a designation of “1b” indicates a facility with “medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.: • Surgery	9	9	8

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

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

*October 1, 2019, through September 30, 2020.

†October 1, 2020, through September 30, 2021.

‡October 1, 2021, through September 30, 2022.

§Unique employees involved in direct medical care (cost center 8200).

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 4, 2024

From: Director, VA Capitol Health Care Network (10N5)

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore

To: Director, Office of Healthcare Inspections (54CH01)

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

1. I have reviewed and concurred with the findings and recommendations concerning the Office of Inspector General's draft report entitled Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore.
2. I have reviewed the response provided by the Medical Center Director, VA Maryland Health Care System. I concur with the corrective actions for recommendation # 2 and 3, which are requested for closure.
3. Furthermore, I have reviewed and concur with the ongoing corrective actions for recommendations # 1, 4, and 5, which remain open and in progress.
4. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Network Office.

(Original signed by:)

Robert M. Walton, FACHE

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 26, 2024

From: Director, VA Maryland Health Care System (512)

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore

To: Director, VA Capitol Health Care Network (10N5)

1. I would like to express my gratitude to the Office of Inspector General Survey Team for their professional and comprehensive survey. I have reviewed the draft for the Office of Inspector General, Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore, report and concur with the recommendations.
2. The VA Maryland Health Care System is submitting an initial response to Recommendations 1 through 5, associated with the OIG Report: Comprehensive Healthcare Inspection Program at the VA Maryland Health Care System, Baltimore, Maryland.
3. Please convey my appreciation to the survey team for assisting us in our continuing efforts to provide the best care possible to our Veteran patients.

(Original signed by:)

Jonathon R. Eckman, P.E.

OIG Contact and Staff Acknowledgments

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