US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather

CHIP Report | 22-00063-220 | September 27, 2023

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Figure 1. *Sacramento VA Medical Center of the VA Northern California Health Care System in Mather.*

Source: https://www.va.gov/northern-california-health-care/locations/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
TJC	The Joint Commission
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 Northern California Health Care System, which includes the Sacramento VA Medical Center, Martinez VA Medical Center, an outpatient clinic at Travis Air Force Base, and other outpatient clinics in California.[1] 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 emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the VA Northern California Health Care System during the week of April 11, 2022. 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. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[1] In 2008, the VA Northern California Health Care System and Department of Defense renewed a sharing agreement for an outpatient clinic at Travis Air Force Base. Institute of Medicine, Committee on Evaluation of the Lovell Federal Health Care Center Merger, Board on the Health of Select Populations, *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations* (Washington, DC: National Academies Press, 2012), chap. 5.

Inspection Results

The OIG noted opportunities for improvement and issued seven recommendations to the System Director and Chief of Staff in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 24.

Conclusion

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.

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 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

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 Northern California 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 emergency department and urgent care center 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): 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 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The VA Northern California Health Care System includes the Sacramento VA Medical Center, Martinez VA Medical Center, an outpatient clinic at the Travis Air Force Base, and other outpatient clinics in California.[5] General information about the healthcare system can be found in appendix B.

The inspection team examined operations from August 14, 2017, through April 15, 2022, the last day of the unannounced multiday evaluation.[6] 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.[7] 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 System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system 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] In 2008, the VA Northern California Health Care System and Department of Defense renewed a sharing agreement for an outpatient clinic at Travis Air Force Base. Institute of Medicine, Committee on Evaluation of the Lovell Federal Health Care Center Merger, Board on the Health of Select Populations, *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations* (Washington, DC: National Academies Press, 2012), chap. 5.

[6] The OIG's last comprehensive healthcare inspection of the VA Northern California Health Care System occurred in August 2017. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in March 2019, and behavioral healthcare and human services reviews in July 2021.

[7] 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.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] 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.[10]

To assess this healthcare system's leadership and risks, the OIG considered several 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 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 system had a leadership team consisting of the System Director; Deputy Director; Chief of Staff; Associate Director, Patient Care Services; Associate Director, East Bay Division; and Associate Director, Sacramento Valley Division. The Chief of Staff and Associate Director, Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

The System Director and Chief of Staff had served in their respective roles since 2013 and 2008. The deputy director position was created in September 2021 and filled in October 2021. The System Director reported that the deputy director position added strength to the leadership team. To help assess the executive leaders' engagement, the OIG interviewed the System Director; Deputy Director; Chief of Staff; Associate Director, Patient Care Services; Associate Director, East Bay Division; and Associate Director, Sacramento Valley Division regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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

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

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

Budget and Operations

The OIG noted that the system's fiscal year (FY) 2021 annual medical care budget of $1,227,544,587 had increased approximately 19 percent compared to the previous year's budget of $1,027,772,761.[11] The Deputy Director reported that spending related to the COVID-19 pandemic and community care were contributing factors to the budget increase.[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 healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[14]

[11] Veterans Health Administration (VHA) Support Service Center.

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed." VA, "Community Care," accessed January 25, 2023, https://www.va.gov/communitycare/.

[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. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

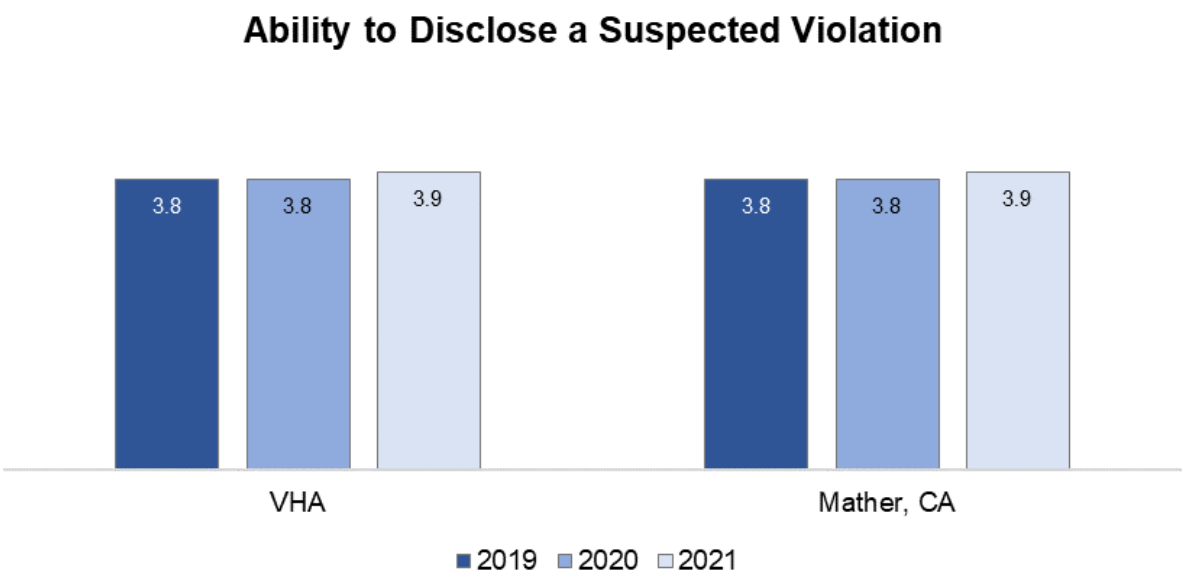

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed March 1, 2022).

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

Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[15]

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 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[17]

[15] "Patient Experiences Survey Results," VHA Support Service Center.

[16] "Patient Experiences Survey Results," VHA Support Service Center.

[17] Scores are based on responses by patients who received care at this system.

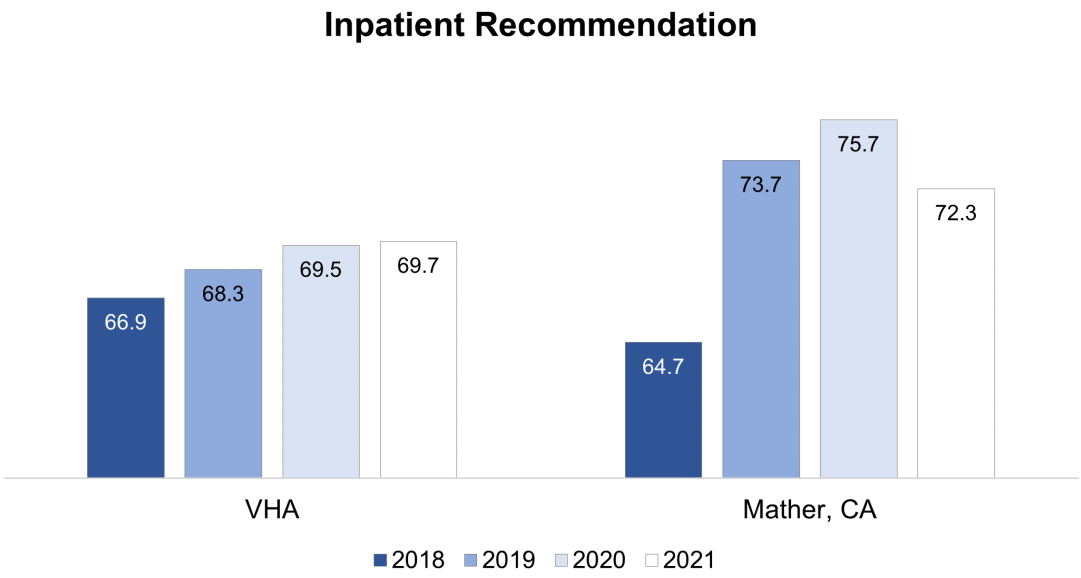

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Definitely yes" responses.

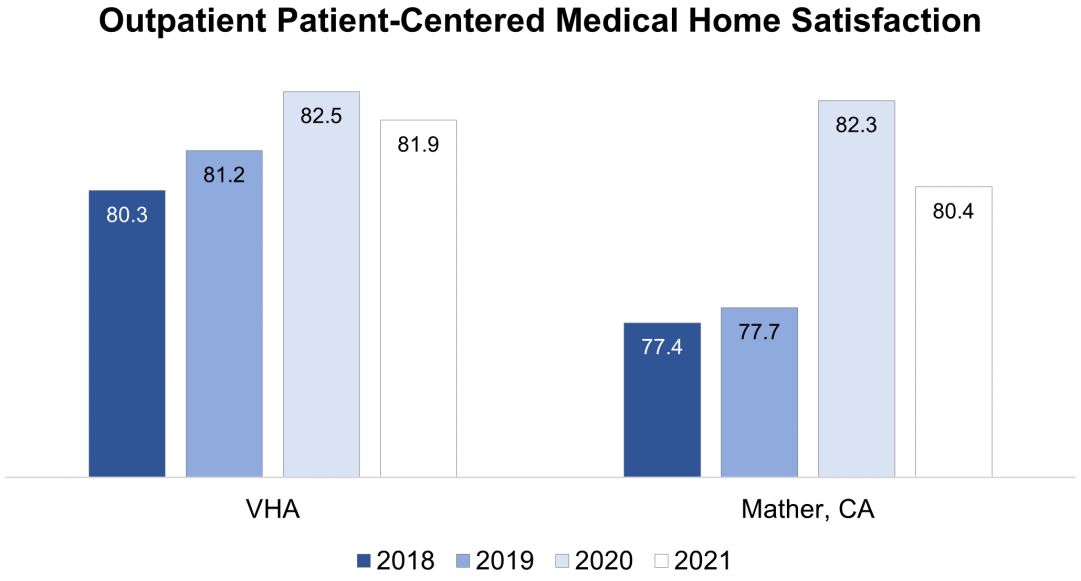

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

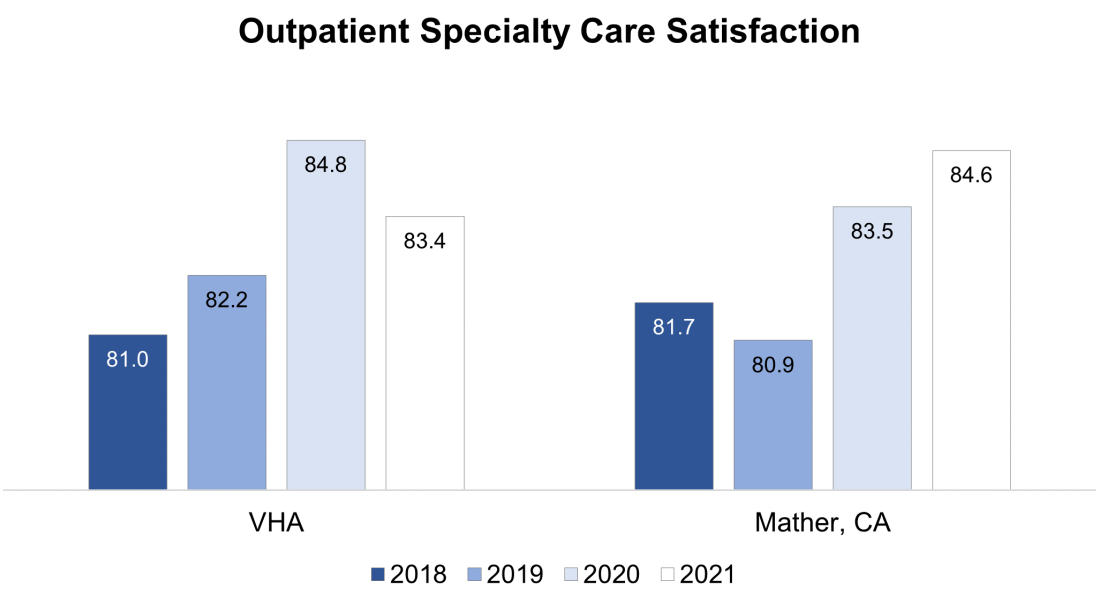

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

Identified Factors Related to Possible Lapses in Care and 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.[18] "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)."[19] 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

[18] 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/.

[19] 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.

recourse."[20] 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."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[22] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[23]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred since August 14, 2017, and reviewed the information staff provided. The System Director described various mechanisms for leaders' awareness of patient safety events, including morning reports, Executive Quality Board monthly meetings, the system's annual VHA National Center for Patient Safety reports, root cause analysis investigations, and weekly executive leadership team huddles with quality management staff.[24] The Associate Director, Patient Care Services explained that the executive leadership team met three times a week for morning reports, where they reviewed the daily management spreadsheet that included joint patient safety reporting events.[25]

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[20] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[21] VHA Directive 1004.08.

[22] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

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

[24] "RCA [root cause analysis] is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01. *VHA Quality and Patient Safety Programs*, March 24, 2023.

[25] VHA's Joint Patient Safety Reporting system "standardizes event capture and data management on medical errors and close calls/near misses." "Frequently Asked Questions," VHA National Center for Patent Safety, accessed July 10, 2023, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[26] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[27] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[28]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[29] 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."[30] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[31]

Finally, the OIG assessed the healthcare system's culture of safety.[32] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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[26] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[27] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[28] VHA Directive 1100.16.

[29] 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.

[30] VHA Directive 1190.

[31] VHA Directive 1190.

[32] 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, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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 reprivileged prior to their expiration.[36]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when a practitioner 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 (OPPE) 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 and aligned under the chief of staff. VHA also requires facilities to have credentialing

[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.

and 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 30 medical staff members who had an FPPE or were reprivileged from March 1, 2021, through February 28, 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the LIP."[40] The OIG found that not all privileging folders had evidence LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. When LIPs are not informed of the evaluation criteria, they may not understand FPPE expectations. The Chief of Staff reported that service chiefs had verbal conversations with newly hired providers but did not document them. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA also requires service chiefs to document professional practice results in the practitioners' profiles and report them to an executive committee of the medical staff.[41] The OIG found that service chiefs did not consistently report FPPE results to the Executive Committee of the Medical Staff Credentialing and Privileging. Additionally, the OIG observed that the committee recommended to renew two practitioners' privileges; however, there were no OPPE data in those practitioners' profiles. Failure of the Executive Committee of the Medical Staff Credentialing and Privileging to review outcomes of professional practice reviews may result in incomplete evidence to support the granting or continuation of clinical privileges. The Credentialing and Privileging Manager reported not receiving all the FPPE documentation from the service chiefs, so the evaluations were not included in the committee's meeting agenda for review. The Credentialing and Privileging Manager also reported that OPPE data were missing for one practitioner due to a change in service lines. The Chief of Staff stated this practitioner's service chief was on extended leave.

[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).

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs document professional practice evaluation results in practitioners' profiles and report them to the Executive Committee of the Medical Staff Credentialing and Privileging.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: The Chief of Staff (COS) will ensure the service chiefs document Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) results in practitioners' profiles and report to the Executive Committee of the Medical Staff Credentialing and Privileging. The Medical Staff Office Manager will track, review, and monitor all completed FPPE/OPPE and ensure results are discussed in the Executive Committee of the Medical Staff Credentialing and Privileging. The numerators are the number of completed FPPE and OPPE that include individual/service/specialty-specific criteria. The denominator is the number of completed FPPE and OPPE each month. The Medical Staff Office Manager will report the monthly compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is achieved and maintained for six consecutive months.

VHA requires that, at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific OPPE data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff.[42] The OIG found service-specific criteria lacking in some of the OPPEs reviewed. This may have resulted in incomplete data to support decisions to continue the practitioners' clinical privileges. The Chief of Staff reported that VHA Central Office Medical Staff Affairs personnel had provided service-specific criteria, which had recently been implemented throughout the various service lines.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures services chiefs base reprivileging recommendations on service-specific Ongoing Professional Practice Evaluation data.

[42] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: On August 15, 2022, Northern California Health Care System (NCHCS) added the Veteran Affairs Central Office (VACO) mandated clinical indicators to all chart review forms; five completed chart review forms are required to complete OPPE forms. The Medical Staff Office Manager will track, review, and monitor all completed focused and ongoing professional practice evaluations and ensure results are discussed in the Executive Committee of the Medical Staff Credentialing and Privileging. The numerator is the number of completed ongoing professional practice evaluation forms that include service/specialty-specific criteria. The denominator is the number of completed ongoing professional practice evaluations each month. The Medical Staff Office Manager will report the monthly compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is achieved and maintained for six consecutive months.

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 the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[43] The physical environment of a healthcare organization must not only be functional but should also promote healing.

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 assessed compliance in 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.[44]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[45] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times to emergencies and contribute to a safe healthcare environment.[46]

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

- Martinez VA Medical Center (East Bay Division)

[43] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.)

[44] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[45] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[46] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone "is a highly effective treatment for reversing an opioid overdose." "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

  - Community living center (Shasta)
  - Primary care clinic (Women's Health)
  - Urgent Care Center
- Sacramento VA Medical Center
  - Behavioral Health Inpatient Care Unit
  - Emergency Department
  - Intensive Care Unit
  - Medical/surgical inpatient unit
  - Specialty care clinic (Urology)

Environment of Care Findings and Recommendations

VHA requires staff to periodically test panic alarms in the inpatient mental health unit and document the VA Police response times.[47] The OIG found evidence of monthly alarm system testing; however, there was no evidence of VA Police response times. This may result in an unsafe environment for patients, visitors, and staff since timely police responses affect the overall success of police intervention and reduce organizational risks. The Physical Security Specialist stated the VA Police responded to panic alarms, but staff did not record the times because they were unaware of the requirement.

Recommendation 3

3. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff document VA Police response times to panic alarm testing in the inpatient mental health unit.

[47] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration,* September 12, 2022, amended October 13, 2022; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," September 30, 2020; VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: The System Director ensures staff document VA Police response times to panic alarm testing in the inpatient mental health unit. VA Police Service tests panic alarms quarterly, including response time. Testing was completed on July 5, 2022; November 4, 2022; March 8, 2023; July 23, 2023; and August 5, 2023; including the average response time of 2-3 minutes with 100% compliance. This will be monitored quarterly until 90 percent or higher compliance is achieved and maintained for two consecutive quarters. This monitor will be reported quarterly to the Executive Quarterly Board (EQB).

VHA states the Director must follow TJC guidelines that require patient care areas to be clean, and furnishings and equipment to be in good working order.[48] Additionally, VHA states the Director must follow TJC requirements for facility staff to continually monitor environmental conditions and requires products be removed from corrugated boxes prior to storage in a clean clinical environment.[49] The OIG found a dirty patient ice and water dispenser, dusty equipment, damaged walls with holes and chipped paint, paper signs taped to walls, corrugated boxes, damaged furniture, patients' personal wheelchairs in a clean equipment room, multiple types of equipment in supply rooms and hallways, supplies stacked on the floor, and damaged ceiling tiles.[50] Environments with pollutants such as dust; damaged furnishings, walls, and ceiling tiles; excess tape; and inappropriately stored supplies are potential infection control concerns.

The Community Living Center Nurse Manager stated that there were storage space challenges throughout the unit, and staff placed patient wheelchairs in the clean equipment room until families were able to pick them up. The Intensive Care Unit Nurse Manager reported requesting 20 replacement chairs and being told by interior design staff that they would order more when funding was available. The Supervisory Safety Specialist explained that a lack of storage space contributed to noncompliance with equipment storage requirements for the hallway outside the Intensive Care Unit, a known exit corridor. The Chief of Environmental Management Services stated that cleaning outside surfaces of ice and water dispensers was an Environmental

[48] TJC, *Standards Manual,* E-dition, EC.02.06.01, January 2020; VHA Directive 1100.16; VHA Directive 1608.

[49] VHA Directive 1100.16; TJC, *Standards Manual,* E-dition, EC 02.06.01, January 2020; VHA Directive 1761, *Supply Chain Management*, December 30, 2020.

[50] Deficient areas were as follows: dirty ice and water dispenser and dusty equipment in the Martinez Urgent Care Center (UCC); dust in the Emergency Department; damaged walls with holes and/or chipped paint in the Martinez UCC, Community Living Center (CLC) Shasta, Emergency Department, Intensive Care Unit (ICU), and medical/surgical unit; paper signs taped to walls in CLC Shasta and Martinez Primary Clinic, Women's Health; corrugated boxes in CLC Shasta, ICU, and Martinez UCC; damaged furniture in the Emergency Department, ICU, and Urology; personal wheelchairs in CLC Shasta; equipment in hallways in the ICU and in the Martinez UCC's medication room and hallways; supplies on the floor in the ICU; and damaged ceiling tiles in Martinez UCC and CLC Shasta.

Management Services staff function; however, they cannot put chemicals inside the machine and therefore would work with engineering staff to take the lines apart and ensure the machine was cleaned. The Chief of Environmental Management Services added that staff were monitoring the ceiling tiles and prioritizing replacement of stained tiles first, then others as more supplies arrived.

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff keep patient care areas clean and maintain furnishings and equipment in good working order.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: On April 20, 2022, the Infection Control Nurse Manager provided a "corrugated box educational poster" to Northern California Health Care System (NCHCS) Center for Rehabilitation and Extended Care (CREC)/Community Living Center (CLC) interdisciplinary staff education. On April 22, 2023, patient wheelchairs and corrugated boxes were removed from the equipment room (S140). The CREC/CLC will assist with identifying additional storage for the CREC/CLC. On April 22, 2023, the CREC/CLC Nurse Manager replaced corrugated boxes with plastic container totes. On April 21, 2022, NCHCS submitted chair order; chairs were received and distributed June 1, 2023. As of July 1, 2022, the ICU hallway was cleared of all equipment; ICU staff lockers were cleaned; corrugated boxes were removed. On July 16, 2022, the ice maker was serviced. As of August 1, 2022, ceiling tiles were replaced. Environment of Care (EOC) rounds are conducted weekly to ensure continued compliance. This will be monitored monthly until 90 percent or higher compliance is achieved and maintained for six consecutive months. This monitor will be reported quarterly to the Executive Quarterly Board (EQB).

VHA requires that all sleeping room doors in the inpatient mental health unit have an over-the-door alarm. Additionally, all over-the-door alarms must be tested according to the manufacturer's guidelines to ensure proper functioning.[51] The OIG found no evidence staff tested over-the-door alarms as required. Nonfunctioning door alarms may increase the likelihood of staff not being alerted to patients' suicide attempts, possibly resulting in completed suicides. The Behavioral Health Inpatient Care Unit Nurse Manager stated that nursing staff check the digital panel for the alarms twice a day. The Supervisory Safety Specialist reported believing this

[51] VHA Directive 1167.

effort met the requirement, although staff only randomly tested some of the actual alarms during bi-annual inspections.

Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff test over-the-door alarms for inpatient mental health unit sleeping rooms as required.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: Per Door Controls USA, Inc. manufacturer's guidelines, the test will be conducted monthly and immediately after a power interruption, fire, storm, earthquake, accident, or any kind of construction activity inside or outside the facility. This will be monitored monthly until 90 percent or higher compliance is achieved and maintained for six consecutive months. This monitor will be reported quarterly to the Executive Quarterly Board (EQB).

VHA requires staff to store medications in a secure manner and reconcile their distribution and usage.[52] The OIG found medications stored outside the automated dispensing cabinet in the Martinez VA Medical Center Urgent Care Center's secure medication room. This creates opportunities for staff to bypass the established medication dispensing system used for accountability and tracking. The Urgent Care Center Nurse Manager reported the automated dispensing cabinet had recently broken; however, the Chief of Pharmacy confirmed there was no indication that the machine had not been functioning properly at any time.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff properly store and secure medications.

[52] VHA Directive 1108.06(2), *Inpatient Pharmacy Services*, February 8, 2017, amended August 26, 2021. (VHA rescinded and replaced this directive with VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.)

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: The Urgent Care Nurse Manager will require staff to store medications in a secure manner and reconcile their distribution and usage. The Urgent Care Nurse Manager will monitor medication security and reconciliation monthly until 90% compliance is maintained for six (6) consecutive months. This monitor will be reported quarterly to the Executive Quarterly Board (EQB).

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[53] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[54]

VHA implemented various evidence-based approaches to reduce veteran suicides, including 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.[55] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[56] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department or Urgent Care Center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 49 randomly selected patients who were seen in the Emergency Department or Urgent Care Center from December 31, 2020, through August 1, 2021.

[53] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[54] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

[55] 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.)

[56] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

Mental Health Findings and Recommendations

VHA requires all patients who are deemed intermediate, high-acute, or chronic risk-for-suicide but safe to be discharged home from the emergency department have weekly follow-up contact until the patient is seen in outpatient mental health care.[57] Of the nine patients discharged from the Emergency Department who were intermediate, high-acute, or chronic risk for suicide, the OIG found one who did not receive follow-up contact within seven days. Lack of follow-up may lead to missed opportunities for staff to provide support, continue risk mitigation, ensure smooth care transition, and monitor continuity of care. The Suicide Prevention Manager reported staff may have missed the patient's follow-up due to an earlier problem with the tracking system lagging up to three days.

Recommendation 7

7. The System Director evaluates and determines additional reasons for noncompliance and ensures staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department.

Healthcare system concurred.

Target date for completion: March 29, 2024

Healthcare system response: The Associate Chief of Staff (ACOS) Mental Health (MH) will ensure staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department.

The ACOS, MH will monitor to ensure staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department monthly until 90% compliance is maintained for six (6) consecutive months.

This monitor will be reported quarterly to the Executive Quarterly Board (EQB)

[57] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives." Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions."

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided seven recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines seven OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs document professional practice evaluation results in practitioners' profiles and report them to the Executive Committee of the Medical Staff Credentialing and Privileging. • Service chiefs base reprivileging recommendations on service-specific Ongoing Professional Practice Evaluation data.
Environment of Care	• Staff document VA Police response times to panic alarm testing in the inpatient mental health unit. • Staff keep patient care areas clean and maintain furnishings and equipment in good working order. • Staff test over-the-door alarms for inpatient mental health unit sleeping rooms as required. • Staff properly store and secure medications.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 21.[1]

Table B.1. Profile for VA Northern California Health Care System (612) (October 1, 2018, through September 30, 2021)

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	$886,419,653	$1,027,772,761	$1,227,544,587
Number of:			
• Unique patients	97,593	96,059	104,024
• Outpatient visits	1,231,605	1,195,686	1,376,578
• Unique employees§	2,988	3,200	3,324
Type and number of operating beds:			
• Community living center	120	120	120
• Medicine	37	42	42
• Mental health	16	16	16
• Surgery	18	18	18
Average daily census:			
• Community living center	118	118	94
• Medicine	39	43	47
• Mental health	11	8	8
• Surgery	8	8	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, 2018, through September 30, 2019.*

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

‡*October 1, 2020, through September 30, 2021.*

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

[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 Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 12, 2023

From: Director, VA Sierra Pacific Network (10N21)

Subj: Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather

To: Director, Office of Healthcare Inspections (54CH03)

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

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather.
2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

(Original signed by:)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2023

From: Director, VA Northern California Health Care System (612)

Subj: Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection conducted at the VA Northern California Healthcare System (VANCHCS) from April 11-15, 2022. I concur with the findings and recommendations in the report.
2. VANCHCS remains committed to ensuring our Veterans receive exceptional health care. Attached, please find the response to each recommendation included in the report.

(Original signed by:)

David Stockwell, MHA
Medical Center Director
VA Northern California Healthcare System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Erin Allman, MSN, RN, Team Leader Edna Davis, BSN, RN Donna Murray, MSN, RN Lauren Olstad, LCSW Teresa Pruente, MHA, RN Estelle Schwarz, MBA, RN Kristie Van Gaalen, BSN, RN Michelle Wilt, MBA, BSN, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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