



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-01910-459

Healthcare Inspection

Quality of Care Concerns at a Mental Health Residential Rehabilitation Treatment Program VA Maryland Health Care System Baltimore, Maryland

December 1, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to complaints regarding documentation and follow-up of clinical events at the Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) located at the Perry Point VA Medical Center, Maryland VA Healthcare System, Baltimore, MD. The complainant alleged that MH RRTP:

- Staff members did not follow sufficient practices to address and manage significant clinical events.
- Staff members did not document significant clinical events in patients' electronic health records.
- Policy-makers knew about the lapses in documentation for significant clinical events but took no action to address them.

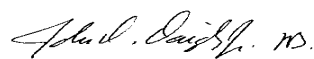
We did not substantiate the allegation that facility staff did not follow sufficient practices to manage significant clinical events. We substantiated the allegation that some staff did not consistently document significant clinical events in patients' electronic health records. We did not substantiate the allegation that subject policy-makers knew of documentation lapses but took no action to correct them. Prior to our inspection, and for unrelated reasons, the current MH Clinical Center Director identified concerns and took steps to revise and improve MH RRTP documentation processes.

We found that the MH RRTP medical provider staffing of 1.2 providers was not compliant with the Veterans Health Administration's required minimum core staffing guidelines of 2.3 providers and that staff did not consistently comply with all safe medication management documentation elements. On September 24, 2014, the Chief of Staff approved the hiring of one additional physician and two mid-level practitioners to cover MH programs.

We recommended that the System Director ensure that MH RRTP medical providers document information pertinent to medical decision-making related to clinical events in the electronic health record, managers review and address medical provider staffing needs, and staff document in the electronic health record all required elements of safe medication management for MH RRTP patients.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–12 for the Directors' comments.) We consider recommendations 1 and 2 closed. We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding a Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) at the VA Maryland Health Care System (system), Baltimore, MD. The complainant alleged that staff did not address or document significant clinical events, and policy-makers knew about but took no action to correct the lapses.

Background

System Profile. The system consists of three campuses—the Baltimore VA Medical Center, the Perry Point VA Medical Center (facility), and the Loch Raven VA Community Living and Rehabilitation Center—and six community based outpatient clinics. The system has 667 total operating beds and provides a range of acute medical, surgical, specialty, and outpatient services. The system has affiliations with the University of Maryland School of Medicine and other local colleges and universities and is part of Veterans Integrated Service Network (VISN) 5.

MH RRTP. In 1995, the Veterans Health Administration (VHA) established the RRTP level of care for patients with MH and/or addictive disorders who do not warrant acute MH inpatient admission but require additional structure and support to address multiple and severe psychosocial deficits.¹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, published December 22, 2010, established procedures and reporting requirements for this level of care.

VHA requires that an RRTP team screen newly admitted patients and determine medical appropriateness for RRTP. Upon entry into a RRTP, patients' diagnoses must be stable and not meet criteria for acute MH or medical admission. At a minimum, the screening team must include a licensed MH professional and a licensed physician or mid-level practitioner (such as a Physician Assistant or Certified Registered Nurse Practitioner).

The facility has four MH RRTPs, including a:

- 23-bed Compensated Work Therapy – Transition Residence
- 30-bed Domiciliary Care for Homeless Veterans
- 71-bed Psychosocial RRTP
- 62-bed Substance Abuse RRTP (the unit); reduced to 33-beds during a 2-year construction project that began in July 2013

¹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

Mid-level practitioners are the primary medical providers for the MH RRTPs. Although they are aligned under the MH Clinical Center (CC), each mid-level practitioner has an assigned collaborating medical physician with whom they can request assistance with medical decisions. A lead mid-level practitioner evaluates the annual performance of the mid-level practitioners with the input of, at least, the facility's Clinical Manager for Residential Care (a nurse manager), the collaborating physician, and an RRTP psychiatrist.

Facility Clinical Leadership. The Chief, Medical Care CC, a position newly filled in fiscal year (FY) 2014, has general oversight responsibilities for the facility's medical care. A MH CC Deputy Director oversees the facility's MH services, and reports to the MH CC Director, who is responsible for system-wide MH services, including the MH RRTPs.

Allegations. The complainant's allegations regarding the unit follow.

- Staff members might not follow sufficient practices to manage serious clinical events.
- Staff members did not document significant clinical events in patients' electronic health records (EHRs).
- Subject policy-makers, including a former MH CC Director, a MH CC Deputy Director, and the collaborating medical physician for the unit's mid-level practitioners, knew about the lapses in documentation for significant clinical events but took no action to address them.

Scope and Methodology

The Office of Healthcare Inspections received the allegation on February 5, 2014, and the period of our review was February 2014 through March 31, 2015. We conducted site visits at the facility April 7–8, 2014, and at the Baltimore VA Medical Center on April 29. We reviewed VHA and local policies, committee minutes, and organizational charts. We reviewed documents, including reports related to patient advocacy, peer review, quality, root cause analysis, and patient safety. We reviewed 27 patient EHRs, of which 12 patients had significant clinical events, from 1 MH RRTP for patients who were admitted during FY 2013 and the first 3 quarters of FY 2014. We interviewed the complainant, key leaders, and staff with knowledge relevant to the allegations.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Issue 1: Management of Significant Clinical Events

We did not substantiate the allegation that unit staff members did not follow sufficient practices to manage significant clinical events.

Of the EHRs included in our inspection, we reviewed the EHRs of 12 patients who had clinical events during their stays on the unit. Of these, eight events were related to patient falls, for which VHA requires implementation of a specific follow-up protocol.² The remaining clinical events included a seizure, a burn from a coffee pot, a scratch from a rusty object, and a scraped knee related to tripping on loose shoelaces.

For all 12 clinical events, the EHRs appeared to have addressed each patient's clinical situation in that afterwards, providers ordered tests or treatments, such as medications, a tetanus immunization, and radiology tests. We could not be certain of the rationale for all medical decision-making because the medical providers did not consistently document progress notes.

Issue 2: Documentation of Significant Clinical Events

We substantiated the allegation that MH RRTP staff members did not consistently document significant clinical events in patients' EHRs.

VHA requires that staff document information related to medical assessment and decision-making in the EHR, including pertinent facts, findings, and observations about a patient's health history, past and present illnesses, examinations, tests, treatments, and outcomes. Further, the EHR is to facilitate, at a minimum:³

- 1. The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor the patient's health care over time.*
- 2. Communication and continuity of care among physicians and other health care professionals involved in the patient's care.*

MH RRTP nurses documented pertinent occurrences in the EHRs of all 12 patients with clinical events. In addition to documenting in the EHR, the nursing staff kept a paper list of patients with clinical issues for the medical providers to address each weekday. Nursing staff reportedly communicated these issues in-person and/or by phone to the medical providers and disposed of the paper list at day's end.

² VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

³ VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012. Newer versions of this Handbook were issued in 2014 and 2015; however, the 2012 Handbook was current during the events described in this report and both the 2014 and 2015 versions have the same requirements as the 2012 ones cited above.

Medical providers did not consistently enter EHR progress notes to explain pertinent medical information, clinical evaluations, and decision-making related to the orders written in 5 of the 12 reviewed clinical events. Of the five EHRs with lapses in documentation, mid-level practitioner A was responsible for four of the missing entries.

We identified several issues that posed challenges to mid-level practitioner A documenting in the EHR, such as the workload volume related to coverage responsibilities during the lengthy absence of a peer mid-level practitioner, lack of a laptop computer, limited shared computer availability due to active construction on the unit, and the distance between buildings. The MH RRTP medical providers were located in building 80 and had to walk nearly two thirds of a mile to the unit's location in building 22 to attend to unit medical care issues, including physical examinations and sick call.

Issue 3: Policy Makers and Lapses in Documentation

We did not substantiate the allegation that policy-makers, specifically a former MH CC Director, the MH CC Deputy Director, and the collaborating medical physician for the MH RRTP's mid-level practitioners, knew of lapses in documentation but took no action to correct them.

Upon interview, the subject policy-makers told us the following:

- The former MH CC Director reported no awareness of documentation lapses and that the unit medical staff “documented very comprehensively.”
- The current MH CC Deputy Director reported being told about “concerns about the lack of notes” (from mid-level practitioner A). After learning of the documentation lapses, the Deputy Director for MH CC met with all program staff to discuss the requirements and was aware that the collaborating medical physician for unit medical staff spoke with mid-level practitioner A.
- The collaborating medical physician for the unit's mid-level practitioners was aware of documentation lapses by mid-level practitioner A and believed that understaffing was a cause. The collaborating medical physician said, “In any given week there are...several hundred notes (and) a tremendous onslaught of work- emails, notes, etc.” In addition, “I have...(except for the newly hired Chief of Staff) been talking about (staffing) to everyone in leadership.”

The current MH CC Director, appointed in July 2013, was aware of the documentation concerns. Prior to our inspection, and for unrelated reasons, the current MH CC Director and lead psychiatrist reviewed several MH RRTP patients' EHRs and identified and addressed mid-level practitioner A's documentation lapses. In subsequent EHR reviews during May and June 2014, they saw significant improvement in mid-level practitioner A's documentation and established plans to continue the review on an ongoing basis. The current MH CC Director also arranged relocation of the mid-level practitioners on July 21 to building 361 where they were co-located with the internal medicine physicians, who can provide direct oversight and case discussion. In addition,

the current MH CC Director was working with quality and other medical staff to revise and improve MH RRTP documentation processes.

Issue 4: MH RRTP Medical Provider Staffing

We found that MH RRTP medical-provider staffing did not comply with VHA requirements.

MH RRTPs must have adequate staffing to provide safe, effective, and appropriate medical care. Medical providers are responsible for the history and physical examination,⁴ laboratory follow-up, and response to acute medical issues. VHA requires minimum core staffing be based on the number of MH RRTP beds and individual clinical staff ratios adjusted to reflect the mission of the program and the needs of the patients served.⁵ Per the guidelines, the facility's MH RRTPs would require a minimum of 2.8 full-time medical providers when all program beds are operational and 2.3 during the construction-related reduced bed capacity.

The facility's organizational chart included 1.2 mid-level practitioners for the MH RRTPs, which did not meet VHA's minimum core requirements for MH RRTP medical provider coverage. In April 2014, MH had a supervisory physician and two mid-level practitioners assigned to the MH RRTPs. However, one mid-level practitioner had been on extended absence, leaving mid-level practitioner A responsible for direct medical care and management of all MH RRTP patients. The supervisory physician provided consultation and education to the mid-level practitioners but did not routinely provide direct patient care.

Medical staff and leadership acknowledged challenges in meeting the demands of this medically complex and diverse population with current staffing pattern and logistics. The facility approved recruitment for the supervisory physician upon the incumbent's retirement in July 2014. On September 24, 2014, the Chief of Staff further approved the hiring of one additional physician and two mid-level practitioners to cover MH programs.

Issue 5: Safe Medication Management

We found that staff did not consistently comply with required elements of MH RRTP safe medication management (SMM).

VHA specifies that patients in MH RRTP programs are able to learn and practice safe management of their medication regimens in order to achieve independent medication administration. When taking medications, some patients may be fully or semi-dependent on staff, while others are independent. A patient's ability to self-manage medication may change throughout his/her participation in the MH RRTP,

⁴ Medical providers are required to complete a medical history and physical examination (H & P) of each patient upon admission to an MH RRTP.

⁵ VHA Handbook 1162.02.

and patients must agree in writing, to comply with all MH RRTP medication security requirements.⁶

Upon admission to an MH RRTP, VHA requires that a physician, mid-level practitioner, or registered nurse conduct medication reconciliation⁷ and assess the patient's current level of knowledge, understanding, and management of his or her medication regime. The staff member who completes the assessment must document this information in the EHR. Using this assessment, a provider must enter an EHR order designating a patient's specific SMM level.⁸ Further, a provider is responsible to educate the patient about each prescribed medication and document the patient's learning needs, education, and understanding. SMM is to be incorporated into the individual treatment plan for MH RRTP patients and is to be reviewed as part of treatment planning updates. VHA also requires that upon a patient's return from an authorized absence (pass), staff must inventory medication, document medication use, and return excess pass medication to the pharmacy.⁹

The 27 EHRs we reviewed included an order for SMM Level 1 (independent), the default order automatically entered when a patient was administratively admitted to MH RRTP. Although required, staff did not document 13 of 27 SMM level assessments for newly admitted patients, including one patient who, in the past, attempted suicide by overdose. On another patient's day of admission, staff assessed the patient as Level 2 (semi-independent) but did not change the order until a week later. In a third case, staff had, upon admission, assessed and ordered the patient's SMM as Level 2 (semi-dependent) but did not discontinue the automatic Level 1 SMM order.

Of the 27 EHRs we reviewed, staff did not document the required admission medication reconciliations in 4 EHRs and medication agreements in 11 EHRs. None of the patients' treatment plans contained SMM level. Staff also did not document the medication inventory of two of five patients who returned from overnight passes.

Conclusions

We did not substantiate the allegation that the facility did not follow sufficient practices to manage serious clinical events. For the 12 clinical events we reviewed, patients' EHRs showed that medical providers had ordered tests or treatments to address each clinical situation.

⁶ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

⁷ Medication reconciliation is the maintenance of accurate, safe, effective medication information by obtaining information from the patient and/or caregivers, comparing the information with the EHR medication list, providing education, and communicating relevant medication information to and between the appropriate members of the VA and non-VA health care team. Source *Patient Centered Medication Information Management & Medication Reconciliation Initiative Update* March 7, 2013.

⁸ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

⁹ Ibid.

We substantiated the allegation that some staff did not consistently document clinical events in patients' EHRs that we reviewed. In most of these cases, mid-level practitioner A did not document pertinent medical information and decisions related to the orders written.

We did not substantiate the allegation that subject policy-makers knew of documentation lapses but took no action to correct them. Prior to our inspection, the current MH Clinical Center Director identified concerns and took steps to revise and improve MH RRTP documentation processes.

We found that the MH RRTP medical provider staffing was not compliant with VHA's required minimum core staffing guidelines of providers. On September 24, 2014, the Chief of Staff further approved the hiring of one additional physician and two mid-level practitioners to cover MH programs. We also found that staff did not consistently comply with all SMM documentation elements in EHRs reviewed.

Recommendations

1. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program medical providers document pertinent information related to medical decision-making in the electronic health record and monitor compliance.
2. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program managers review and address medical provider staffing needs in the Mental Health Residential Rehabilitation Treatment Program.
3. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program staff complete all required elements of the safe medication management program.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 21, 2015

From: Acting Director, VISN 5 VA Capitol Healthcare Network (10N5)


Subj: Healthcare Inspection—Quality of Care Concerns at a Residential Rehabilitation Treatment Program, VA Maryland HCS, Baltimore, Maryland

To: Director, Baltimore Office of Healthcare Inspections (54BA)

1. We appreciate the opportunity to review and provide comments to the Draft report of the VA Office of the Inspector General, Healthcare Inspection, Quality of Care Issues at a Mental Health Residential Rehabilitation Treatment Program (MH RRTP), VA Maryland Health Care System (VAMHCS) Baltimore, Maryland, from February 2014 through March 31, 2015. Site visits were Conducted at the MH RRTP at the Perry Point VA Medical Center on April 7-8, 2014, and at the Baltimore VA Medical Center on April 29, 2014. The findings and recommendations have been reviewed with senior leadership at the VISN and VAMHCS.

2. We concur with the recommendations in this report. The VAMHCS staff has already begun to implement improvement actions.

3. If you have any questions, please contact Jeffrey Lee, Quality Management Officer, at 410-691-7816.



Joseph A. Williams, Jr.

Joseph A. Williams, Jr., RN, BSN, MPM

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 20, 2015

From: Acting Director, Perry Point VAMC – VA Maryland Health Care System (512/00)

Subj: Healthcare Inspection—Quality of Care Concerns at a Residential Rehabilitation Treatment Program, VA Maryland HCS, Baltimore, Maryland

To: Acting Director, VISN 5 VA Capitol Healthcare Network (10N5)

1. I appreciate the opportunity to review and provide comments to the draft report of the VA Office of Inspector General Health Care Inspections' review of the Quality of Care Issues at a Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP), VA Maryland Health Care System (VAMHCS), Baltimore, Maryland, from February 2014 through March 31, 2015. Site visits were conducted at the MH RRTP at the Perry Point VA Medical Center on April 7-8, 2014, and at the Baltimore VA Medical Center on April 29, 2014. The findings and recommendations have been reviewed with senior leadership at the VAMHCS.
2. I concur with the recommendations in the report. The VAMHCS staff has already begun to implement improvement actions.
3. If you have any questions, please contact my office at 410-605-7016.


Adam M. Robinson, Jr., M.D.

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program medical providers document pertinent information related to medical decision-making in the electronic health record and monitor compliance.

Concur

Target date for completion: Completed

Facility response: A new process was established and fully implemented in late July 2014 that requires all contacts with the medical PAs serving the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) to be scheduled into a specific clinic in CPRS. By utilizing the electronic medical record (as opposed to the paper sheets used previously), we have been able to track encounters and workload in real time. Further, once patients are seen in the clinic, there is a requirement for specific documentation to be completed before the encounter can be "closed". The process now allows each patient encounter to be tracked and reviewed for quality.

On Friday July 18, 2014, information regarding the new clinic process was provided to all Perry Point VAMC MH and MH Nursing staff. These stakeholders were educated about the new process and were provided a step-by-step plan designed to assist the Veterans with locating and registering for the newly formed and centralized clinic. The new Clinic began on Monday July 21, 2014.

When comparing workload data for the MH RRTP PA from before implementation (Quarter 1 FY14) of the new streamlined clinic process to just after implementation (Quarter 1 FY15), we found a 61% increase in patient visits and a 95% increase in compliance of medical documentation.

In terms of quality, the MH RRTP PA was given direct oversight by a Medical (non-psychiatrist) attending at the Perry Point VAMC. Further, 10% of all encounters over Q1 FY2015 (56 individual charts) were reviewed and found to be 100% in compliance with all required medical documentation including, but not limited to, documentation of: chief complaint, review of the history of present illness, review of past medical history, review of vital signs, physical examination, review of appropriate laboratory and imaging studies, use of appropriate consultants, medication reconciliation and resultant impression and full plan of care.

Quality and workload continue to be monitored and assessed as part of the ongoing professional practice evaluation (OPPE) that is in place for all providers at the VA

Maryland Health Care System. The MH RRTP PA continues to complete all documentation related to medical decision-making in the electronic health record.

Finally, and in a larger sense, the re-organization of this clinical process has become a valued therapeutic component of the rehabilitative goals of the RRTP. Many Veterans under the care of the RRTP have specific treatment goals centered around successful transition from an institutional setting, such as an inpatient MH unit, to re-integration within their own local communities. By providing increased structure to the method by which medical care is provided, we are presenting to the Veterans under our care an opportunity to recover skills and independence that will prove valuable after discharge and moving forward.

Recommendation 2. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program managers review and address medical provider staffing needs in the Mental Health Residential Rehabilitation Treatment Program.

Concur

Target date for completion: Completed

Facility response: Given the current construction phase of the residential programs at Perry Point, VACO Residential Handbook guidelines recommend 2.3 FTEE dedicated to providing medical care. At this time there are 4.0 FTEE dedicated to providing care. One Physician (1.0 FTEE) started on April 19, 2015 and another Physician (1.0 FTEE) was hired and began work on June 1, 2015. These positions were added to two existing Physician Assistants (2.0) FTEE. In addition, there are plans to hire a full time Nurse Practitioner as soon as he is boarded, as well as transfer another Physician Assistant from Baltimore.

Recommendation 3. We recommended that the System Director ensure that Mental Health Residential Rehabilitation Treatment Program staff complete all required elements of the safe medication management program.

Concur

Target date for completion: 12/31/15

Facility response: In order to ensure that Mental Health Residential Rehabilitation Treatment Program staff complete all required elements of the safe medication management program (SMM), a chart audit tool will be developed. Additionally, a random audit of 10 charts each month will be conducted. The audit will be discontinued when three consecutive months of 100% compliance on all parameters of the audit tool are met. The following parameters will be assessed each month:

- 1) Has Veteran signed an agreement to comply with all MH RRTP medication security requirements?

- 2) Is the Medication Reconciliation documented upon admission?
- 3) Has the Veteran's level of SMM been assessed and documented in the record at admission?
- 4) Has the Physician entered the order for the level of SMM in CPRS?
- 5) Does the SSM assessment and order level match?
- 6) Has nursing staff documented educating the Veteran regarding SMM procedures?
- 7) Does the treatment plan contain objectives related to SMM?
- 8) Is there evidence of monthly updates to the SMM in the treatment plan updates?
- 9) If a Veteran was prescribed pass medication, was the Veteran assessed upon return, medications inventoried, and any excess medications returned to the pharmacy?

OIG Contact and Staff Acknowledgments

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| Contact | For more information about this report, please contact the OIG at (202) 461-4720. |
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| Contributors | Sonia Whig, MS, LDN – Team Leader Terri Julian, Ph.D. Alan Mallinger, MD Melanie Oppat, MEd, LDN Nicholas DiTondo, BA Program Support Assistant |
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