Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Community Residential Care Program Review
VA Maryland Health Care System
Baltimore, Maryland

Report No. 06-02265-106 **March 23, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

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Executive Summary

The purpose of this inspection was to determine the validity of multiple allegations pertaining to patients in the VA Maryland Healthcare System (the system), Community Residential Care (CRC) program. These allegations included alleged abuse of patients; financial exploitation of patients; placing patients in unlicensed or unapproved homes; mismanagement of the CRC homes; and poor communication among VA CRC program staff, Mental Health Intensive Case Management (MHICM) program staff, and other system staff.

Although we substantiated that a patient was fed food that was past its "use-by" date, we concluded the patient was not harmed. Furthermore, we found no other outdated food during our review. We found that all patients in the CRC program reside in State licensed homes. There are patients in the MHICM program who do not reside in State licensed CRC-approved homes, but there are valid reasons. In addition, veterans are made aware of the home's status prior to placement and sign a waiver indicating they know about the unapproved status of the home. With regard to financial exploitation, we found that there were instances of facility operators/sponsors taking loans from veterans. Appropriate corrective actions were taken by the VA CRC staff. However, the CRC staff needs to review, approve, and document financial transactions and arrangements between sponsors and patients. At the time of our review, all CRC homes had a Delegating Nurse (a nurse to supervise unlicensed CRC home staff who pass medications to patients). CRC sponsors had completed background checks on all staff as required, and State home inspections were current. However, we substantiated that not all CRC homes were visited monthly by CRC staff and that documentation of appropriateness for continuing in the CRC program and annual physical exams were not always documented. Furthermore, there were inter-departmental communication problems and documentation deficiencies.

We made recommendations that:

- VA CRC staff review, approve, and document all financial transactions and arrangements between sponsors and patients.
- Monthly visits to patients are conducted and documented.
- Annual physicals are performed and appropriateness for continued stay in CRC homes is documented.
- VA CRC and MHICM staff meet regularly and document pertinent issues.

System management agreed with our findings and recommendations and submitted acceptable implementation plans. We will follow up on the planned actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 5 (10N5)

SUBJECT: Healthcare Inspection - Community Residential Care Program Review VA Maryland Health Care System, Baltimore, MD

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received multiple allegations pertaining to patient care issues in the VA Maryland Healthcare System (the system) Community Residential Care (CRC) program. These allegations included alleged abuse of patients; financial exploitation of patients and mismanagement of patients' funds by CRC facility operators/sponsors;[1] placement of patients in unlicensed or unapproved CRC homes; mismanagement of CRC homes; and poor communication among members of the VA CRC staff, Mental Health Intensive Case Management (MHICM) staff, and other system staff. The purpose of this inspection was to evaluate the validity of the allegations.

Background

The system offers a full range of inpatient, outpatient, and primary care services. The system consists of three divisions: the Baltimore medical center and campuses at Perry Point and Loch Raven. The system operates 727 authorized beds. The Perry Point Campus offers long term inpatient, outpatient mental health, and domiciliary care for patients; it is also the site of the system's CRC program management. The CRC Program consists of 50 homes.

Since 1951, the VA CRC program has provided health care supervision to eligible patients not in need of acute hospital care, but who, because of medical and/or psychosocial health conditions, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. The CRC program is an important component in the VA's continuum of long term care.

[1] "Facility Operator (Sponsor). A facility operator assumes the management responsibility for the facility and may or may not be the provider. NOTE: *Historically, the facility operator has been called the sponsor.*" VHA Handbook 1140.1, *Community Residential Care Program*, March 7, 2005.

services. Before patients are placed in CRC homes, the home must first meet state licensing requirements and then pass an extensive VA inspection. Patients are placed in CRC homes by VA CRC social workers and case managers. Placement is made in residential settings inspected and approved by the VA but chosen by the patient. On May 23, 2006, we received complaints of multiple deficiencies in the system's CRC program.

The themes of the allegations centered on mismanagement of the CRC program by VA staff. They may be categorized as follows:

- Patient Abuse. It was alleged that an elderly female patient was given expired food and did not have her diapers changed for 4 days.
- Patients Reside in Unlicensed or Unapproved Homes. It was alleged that the MHICM team was sending patients to unapproved homes, CRC sponsors inappropriately moved patients between approved and unapproved homes, and patients (not enrolled in the CRC program) reside in CRC homes without the knowledge of VA CRC staff.
- Financial Exploitation of Patients by CRC Sponsors. It was alleged that patients work in CRC homes without compensation or for cigarettes, and that CRC sponsors borrow patients' funds.
- Lack of a Delegating Nurse.[2] It was alleged that not all CRC homes have a delegating nurse.
- Mismanagement of CRC Homes. It was alleged that VA CRC staff failed to make required monthly visits to CRC homes. It was also alleged that CRC homes failed to complete required background checks for all employees, did not have current State inspections, and did not report adverse events to appropriate VA CRC staff. It was further alleged that there are more patients living in one of the CRC homes than the home is licensed for, that patients at CRC homes do not receive annual physicals, and that CRC staff do not receive appropriate required annual training.
- Poor Communication. It was alleged that there was poor communication among members of the VA CRC staff, MHICM staff, and other system staff.

Scope and Methodology

On July 10–14, 2006, we conducted a site visit at the Perry Point campus to review the CRC program. Prior to our visit, we conducted a telephone interview with the complainant in order to clarify the initial written allegations received by the OIG. We interviewed the complainant, the CRC Director, the Director of the Geriatric and Extended Long Term Care Service, who is also the medical director for the CRC

[2] In Maryland, a nurse may delegate the responsibility to perform specific nursing tasks to an unlicensed individual who meets certain criteria. The administration of medications is one of these tasks. The delegating nurse is required to visit the CRC home every 45 days to oversee the administration of medications.

program, and clinicians involved in the care of the patients referred to in the complainant's allegations. We reviewed available medical records, pertinent medical center policies and procedures, and other documents relevant to the case. We also visited 15 CRC homes, where we reviewed documentation pertinent to the care of patients and interviewed sponsors of the homes and patients residing in these homes.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Findings and Conclusions

Issue 1: Alleged Patient Abuse

This allegation was not substantiated.

The complainant alleged that an elderly female patient was fed food with expired "use by" dates (obtained from a local food bank), stayed in soiled diapers for 4 days, and the VA Home Based Primary Care (HBPC) staff did not provide proper care for the patient.

The HBPC staff provides VA nursing care in the community and in CRC homes. The 83-year-old patient, who has resided at various times in two different CRC homes owned by the same sponsor, has a medical history that includes depression, gastroesophegeal reflux disease, hypertension, chronic back pain, osteoporosis, and chronic diarrhea. On January 26, 2006, the patient was referred to the HBPC program by a VA CRC social worker for "multiple medical problems and homebound" status.

On February 3, a HBPC nurse practitioner completed the initial Evaluation/Treatment Plan for the patient. After this initial assessment, the nurse practitioner reported concerns about outdated Isomil (liquid feeding) the patient had received and an ulcer on the patient's heel to a VA CRC social worker.

We reviewed all electronic clinical note entries between February 3 and May 12. The patient was seen by Vascular Surgery clinicians for evaluation of the heel ulcer on March 6, and it was noted to be almost completely healed and less than 1 centimeter in diameter. On May 3, VA CRC staff described the heel ulcer as a small red pressure area. The CRC staff also documented that the patient complained that the CRC sponsor refused to change her diaper. HBPC staff documented on several occasions that the patient was clean and dry. We did not find any other documentation indicating improper delay in changing the patient's diapers or that the patient was kept in soiled diapers for an inappropriate length of time.

In late May, the patient moved to a new unapproved CRC home that was managed by a former employee of the home from which she had moved. This move was approved by the patient's daughter, who had legal authority to make health care decisions for the

patient and was aware of the unapproved status of the new home. At the time of our inspection, the home sponsor had applied for State licensure and had requested VA CRC approval. The patient continues to be followed by HBPC at this home.

We visited 15 additional CRC homes and checked expiration dates on samples of the food served to the patients. No outdated food was discovered. We made no recommendations.

Issue 2: Alleged Residence of Patients in Unlicensed or Unapproved Homes

We substantiated this allegation. However, patients enrolled in the MHICM program are able to be placed in unapproved homes under certain specific circumstances.

The complainant alleged that patients were placed in unapproved homes by MHICM and system personnel not involved in the CRC program, and that patients were placed in homes not licensed by the State. We found that all patients enrolled in the CRC program reside in State licensed homes. However, patients enrolled in the MHICM program may reside in homes not licensed by the State. The system Mental Health Care Service and the MICHM teams are both authorized by the VA and mandated by the North East Program Evaluation Center (NEPEC) to facilitate the community placement of patients with a history of frequent psychiatric admissions. NEPEC is responsible for designing, implementing, and evaluating innovative mental health programs that have facilitated the transformation of the VA mental health care system from a traditional, hospital based system, to an information-driven community based system. NEPEC requires that MHICM patients are placed in the least restrictive environment possible in order to foster mental health recovery. MHICM staff are authorized to place patients in unapproved housing when placement within a CRC approved home is not appropriate or possible (such as too expensive, too restrictive, no other vacancies available, or the patient refused). In such circumstances, the patient signs a "waiver" acknowledging that the patient is aware of the unapproved status of the home.

In April 2006, a patient was admitted into the MHICM program and placed in an unapproved home after he signed a waiver agreeing with the placement. We also found that several other MHICM patients reside in homes that are State licensed but not VA-approved CRC homes; they also signed waivers agreeing with the placement. We made no recommendations.

Issue 3: Alleged Financial Exploitation of Patients by CRC Home Sponsors

We substantiated this allegation.

Patients must be allowed to manage their own personal financial affairs except when restricted in this right by law or by the plan of needed care. If the patient requests assistance in managing personal financial affairs, the request must be documented in the electronic medical record and evaluated by the CRC program coordinator and other

clinicians as appropriate. When a CRC home gets approved by the VA, the sponsor is provided with a CRC handbook and signs a contract with the VA, which includes a provision prohibiting the borrowing of funds from patients under any circumstances.

On January 30, 2006, a VA CRC staff member was notified that a patient loaned $600 to his CRC sponsor, who reportedly repaid $200 leaving a balance of $400. On February 6, the CRC program coordinator was notified of the situation; on February 7, a CRC social worker discussed the incident with the sponsor, confirming the existence of a loan. The CRC social worker requested that the balanced owed to the patient be paid within 3 weeks, and instructed the sponsor not to borrow any additional funds at any time, in accordance with the VA contract. The social worker interviewed the four additional patients living at that home; they denied loaning any funds to the sponsor. This home was subsequently removed from the CRC program by the system director.

When the home was removed from the CRC program, three of the patients were relocated to another CRC home on March 20. The patient who had originally loaned his sponsor $600 was admitted to the system's Long Term Care Geriatrics Medical Unit for follow-up regarding a chronic medical condition. The $400 owed to this patient was paid in full.

On April 6, two of the four patients who had been interviewed previously admitted that they had loaned $1,500 to the sponsor of the home and $60 to the sponsor's friend. The social worker hand delivered a letter to the sponsor of the home demanding repayment of these loans. The sponsor signed a statement admitting that she had borrowed these additional funds and agreed to repay them.

The social worker contacted the two patients on May 15, and they stated that the funds had not been repaid. The social worker contacted the Maryland Office of the Attorney General and was instructed to contact the local police, which she did. The police went to the sponsor's home and requested that she repay the funds. The sponsor signed a statement stating that she would repay these funds. The social worker informed the patients' family members of the VA action taken and notified them of possible avenues of redress. To date, these two patients have not been repaid.

The VA CRC staff sent letters to all CRC sponsors in the program reminding them of the prohibition against borrowing money from patients; citing the Code of Maryland Regulations, VA CRC Handbook, and the CRC contract; and stating that failure to abide by this contract would result in termination of the contract and the removal of patients from sponsor's homes.

VHA guidelines require documentation in the electronic medical record of all financial arrangements made with the patients or their representatives. Financial arrangements may include, but are not limited to, money for vacation, clothes, and arrangements made to hold a patient's room at the home if the patient is hospitalized. We reviewed the

medical records of 50 patients and found documentation of financial arrangements in 22 cases (44 percent).

Recommendation 1. We recommend that the VISN Director ensure that the System Director requires the CRC Program Coordinator to: (a) review, approve, and document all financial transactions and arrangements between sponsors and patients; (b) take administrative action against sponsors who take loans from patients; (c) with the advice of Regional Counsel, notify, in writing, all patients still owed money of their legal options to recover their monies; and (d) monitor the cases until all monies are recovered.

Issue 4: Alleged Lack of a Delegating Nurse

We substantiated this allegation but found that managers had taken appropriate actions.

In Maryland, a nurse may delegate the responsibility to perform a nursing task to an unlicensed individual who has taken a required medication administration course or a certified nursing assistant, provided the task is within the area of responsibility of the nurse delegating the act. The administration of medications is one of these tasks. The delegating nurse is required to visit the CRC home every 45 days to review patient medication records and to compare this record with physician orders. All CRC sponsors and staff giving medications must be certified by the State every 2 years. Certified individuals are listed on the Maryland State Nursing Web page. CRC homes that do not have a delegating nurse are reported to the Maryland Office of Health Care Quality, which may revoke the CRC home license or implement a plan of correction.

One of the approved CRC homes did not have a delegating nurse for 4 months when their delegating nurse moved out of the area. The CRC Program Coordinator worked with the home and a delegating nurse was found to perform the task. At the time of our review, all 50 licensed CRC homes that house patients and are followed by the VA CRC and MHICM programs had delegating nurses. We made no recommendations.

Issue 5: Alleged Mismanagement of CRC Homes

We substantiated some of the complainant's allegations concerning mismanagement.

Monthly Visits. VHA guidelines require that each patient receive a visit from the VA CRC program staff at least monthly. The purpose of the visit is to make sure the patient is adjusting to the home and to address any questions or problems that the sponsor or patient may have. We reviewed the medical records of 50 patients participating in the CRC program. Over the past 2 years, 21 of the 50 patients (42 percent) in the CRC program were visited on a monthly basis.

Annual Physicals. Each year patients in CRC homes are required to have a physical examination and determination of the appropriateness of continued CRC placement documented in their medical record. In our sample of 50 patient medical records, from

fiscal year 2005 documentation we found 5 records (10 percent) that had no documentation of an annual physical, and 44 records (88 percent) that had no documentation regarding the patient's appropriateness for continuing in the CRC program.

Background Checks. The complainant alleged that CRC sponsors failed to conduct background checks and that patients were placed in a home managed by a convicted felon. CRC homes are required to submit background checks for caregivers employed at the homes to both the state and system inspection teams. Background checks are required of the sponsor and any person who is employed or provides care. Family members such as spouses, adult children, and significant others are not required to have background checks if they are not providing care to the patients.

At the time of the original allegation, not all CRC home employees had completed background checks. At the time of our inspection, however, all background checks were current. The system needs to have a process to verify that background checks are current.

The sponsor of a State licensed and VA approved CRC home in the city of Baltimore is a felon convicted many years ago. The sponsor submitted his background check, including his criminal record, to the State licensing board and to system employees. The information, along with other information concerning the sponsor's positive community activities, was considered by the CRC Program Coordinator in making the decision to approve the home. There is one patient enrolled in the MHICM program who has resided in this home since March 1, 2005. The patient reported that he is satisfied with his living arrangements and denied any concerns or complaints regarding the owner of the home.

State Inspections Incomplete. The complainant also alleged that State inspections were not completed at several CRC homes. We contacted the State licensing board and were told that the inspection schedule is backlogged. At the time of our inspection, all VA approved CRC homes had current inspections.

Patients Working in CRC Homes. It was alleged that CRC homes require patients to work but were not providing fair compensation. Under current CRC guidelines, patients will not perform household duties, other than personal housekeeping tasks, unless they receive compensation for these duties, or are told in advance that the duties are voluntary and they agree to perform the duties without compensation. We found one patient residing at a CRC home who performed "odd jobs" for the sponsor. However, the sponsor paid the patient and also withheld appropriate state and Federal taxes.

Overcrowding. Each CRC home is licensed to house up to a maximum number of patients in the home. If a home wishes to exceed the maximum limit, it must apply to the state for an increase in the number of patients allowed to reside in the home. It was alleged that one of the homes had 11 patients and it was only licensed for 10 patients. We found that the home did have 11 residents. Ten patients were living in the assisted

living part of the home. The other resident was a former patient who had graduated from the MHICM program and had an apartment that was connected to the assisted living part of the home. The 11th resident was living independently and renting the apartment from the sponsor.

We visited 15 of the system's 50 CRC homes (30 percent) and found they all had current State licenses, appeared well managed and clean, and the sponsors were able to provide required documentation (such as license and proof of a delegating nurse) upon our request. The patients we spoke with knew the VA CRC staff who accompanied us, reported satisfaction with their care, and did not voice any complaints. The CRC sponsors reported good working relationships with the VA CRC and MHICM staff and responsiveness when management problems have arisen with patients.

Recommendation 2. We recommend that the VISN Director ensure that the System Director requires that CRC staff: (a) conduct and document monthly visits to patients in the CRC homes, (b) ensure annual physical examinations are performed and fitness for continuing stay assessments are documented, and (c) verify that employee background checks are current.

Issue 6: Alleged Poor Communication Among Staff

We substantiated this allegation.

The staff we interviewed complained of poor communication between staff members within the CRC program itself, between staff in the CRC and MHICM programs, and between CRC staff and mental health clinicians. We found that there were no scheduled joint meetings between CRC and MCHICM staff. In addition, we did not find documentation of discussions of mutual patient concerns between employees in the different programs. CRC program staff met regularly to discuss the CRC homes, the sponsors, and the patients residing in these homes; but there was no documentation of these meetings or of decisions made as a result of these meetings.

Recommendation 3. We recommend that the VISN Director ensure that the System Director requires the CRC program coordinator to: (a) improve medical record documentation in accordance with VHA regulations; (b) create an accounting system that enables the CRC staff to accurately track CRC monthly visits, CRC home employee background checks, training records, and annual CRC home inspections; and (c) conduct regular staff meetings and document pertinent issues relevant to the CRC program and MHICM program.

Comments

The VISN Director and System Director concurred with the findings and recommendations and have begun taking actions to implement the recommendations in this report. (See Appendix A, pages 10–15 for the complete text of their comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 5, 2006

From: Network Director, VISN 5

Subject: **Healthcare Inspection - Community Residential Care Program Review VA Maryland Health Care System**

To: Director, Management Review and Administrative Service (10B5)

1. This memorandum is in reply to the Community Residential Care Program Review, VA Maryland Health Care System.

2. I concur with the corrective actions submitted in the attached memorandum from the VAMHCS Director.

3. Should you have any question or concerns, please contact Dr. Archna Sharma, Quality Management Officer, at 410-691-1142.

for JAMES J. NOCKS, M.D., M.S.H.A.

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 27, 2006

From: Director, VA Maryland Health Care System (BT/00)

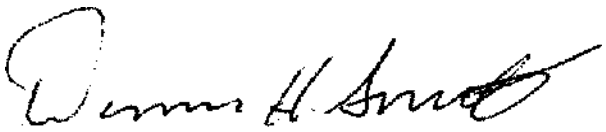
Subject: **Healthcare Inspection - Community Residential Care Program Review VA Maryland Health Care System**

To: Assistant Inspector General for Healthcare Inspections 54

1. Thank-you for the opportunity to respond to this draft report, which identifies improvement opportunities in the management and oversight of VAMHCS Community Residential Care Program.

2. Thank-you again for your thoughtful and meticulous review of the allegations. Your assistance in helping us focus on program improvement of our CRC Program is greatly appreciated and helpful. Our leadership and dedicated CRC staff look forward to continuing the excellent service and commitment to our veterans.

3. If any additional information is needed, please contact, Betsy Bradford, RN, MHA, GLTC, Business Manager, 410-642-2411, extension, 6352.



DENNIS H. SMITH

Attachment

MDH/brb:

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensures that the System Director require the CRC Program Coordinator to:

(a) Review, approve, and document all financial transactions and arrangements between sponsors and patients.

Concur **Target Completion Date:** 12/1/2006

Corrective Action: CRC Sponsors are educated that they are not to request/accept loans from the veterans in their care. CRC Social Work will document in their monthly notes, under "*Financial Transactions*", any financial dealings between veterans and their sponsors. All requests for funds from the veteran will be recorded in CPRS and reviewed, approved, and cosigned by the CRC Program Coordinator.

(b) Take administrative action against sponsors who take loans from patients.

Concur **Target Completion Date:** 7/27/2006

We consider this a recommendation to continue present practice as illustrated in the case reviewed by the OIG team. As of the date of the review, all letters had been sent and we were awaiting action by the courts. All loans were settled as of July 27, 2006. We have consistently provided education to our patients and CRC sponsors not to engage in the loaning of money. Each of the incidents involved a single CRC sponsor who has subsequently been removed from the program.

(c) With the advice of Regional Counsel, notify, in writing, all patients still owed money of their legal options to recover their monies.

Concur **Target Completion Date:** 7/27/2006

We consider this a recommendation to continue with present practice illustrated in the case reviewed with the OIG team.

(d) monitor the cases until all monies are recovered.

Concur **Target Completion Date:** 7/27/2006

Corrective Action: Each of the three cases were monitored until all monies had been repaid in full to the satisfaction of the veteran and/or his advocate.

Recommendation 2. We recommend that the VISN Director ensure that the System Director requires that CRC staff:

(a) Conduct and document monthly visits to patients in the CRC homes.

Concur **Target Completion Date:** 12/15/2006

Corrective Action: All CRC residents are visited monthly and findings are documented by the CRC Social Worker. The CRC Coordinator is responsible for monitoring documentation and reports to the CRC Oversight Committee and the GLTC PI [Geriatric and Long Term Care Process Improvement] Sub-Council.

(b) Ensure annual physical examinations are performed and fitness for continuing stay assessments are documented.

Concur **Target Completion Date:** 11/20/2006

Corrective Action: The CRC Social Worker will monitor the date of the veteran's annual physical to ensure they are seen within the appropriate timeframe. Social Work staff have added "verification of fitness for continuing stay and appropriate placement in CRC" to their documentation. The CRC Coordinator is responsible for monitoring documentation and reports quarterly to the CRC Oversight Committee and the GLTC PI Sub-Council

(c) verify that employee background checks are current.

Concur **Target Completion Date:** 7/31/2006

All background checks are verified during scheduled inspections. We consider this as a recommendation to continue with the practice illustrated in the case reviewed with the OIG Team.

Recommendation 3. We recommend that the VISN Director ensures that the System Director requires the CRC program coordinator to:

(a) Improve medical record documentation in accordance with VHA regulations.

Concur **Target Completion Date:** 11/1/2006

Corrective Action: All CRC medical records are peer reviewed quarterly. Findings are reported to and reviewed by the VAMHCS Social Work Practice Council on a biannual basis. All notes are documented in accordance with VHA regulations.

(b) Create an accounting system that enables the CRC staff to accurately track CRC monthly visits, CRC home's employee background checks, training records, and annual CRC home inspections.

Concur **Target Completion Date:** 7/31/2006

Corrective Action: The tracking system has been modified to be more user friendly and is available on the shared drive for ease of access by program staff.

(c) Conduct regular staff meetings and document pertinent issues relevant to the CRC and MHICM program.

Concur **Target Completion Date:** 11/15/2006 and 12/15/2006

Corrective Action:

1) The CRC Monthly staff meeting now includes a standing agenda item specifically addressing CRC and MHICM issues. Target Date: November 15, 2006. Complete.

2) A CRC Oversight Committee was created to include: Nursing leadership, Performance Improvement, Engineering, CRC Education, CRC Nursing, GLTC Director and Business Manager, and Coordinators of the *CRC and MHICM* programs. Target Date: December 15, 2006.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, JD, Associate Director, Office of Healthcare Inspections, Washington, DC 202-565-8452
Acknowledgments	Gail Bozzelli Donna Giroux Nelson Miranda Michael, Shepherd, MD Carol Torczon

Appendix D

Report Distribution

VA Distribution

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Director, VA Maryland Health Care System

Non-VA Distribution

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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara A. Mikulski, Benjamin L. Cardin
U.S. House of Representatives: Elijah E. Cummings

This report is available at http://www.va.gov/oig/publications/reports-list.asp.