



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Primary Care Providers’ Completion of Electronic Health Record Documentation at the VA Augusta Health Care System in Georgia

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the VA Augusta Health Care System (system) in Georgia from May 12, 2025, through January 28, 2026, including an on-site visit from June 24 through 26, 2025. The OIG team assessed whether system leaders maintained oversight of primary care providers' required processing of electronic health record (EHR) view alerts and completion of documentation following patient visits. The OIG also evaluated whether system leaders delayed initiating the state licensing board reporting process following removal of a primary care provider from employment.

View Alerts

View alerts are notifications sent through EHRs to providers, including primary care providers, that communicate information such as results of laboratory tests, diagnostic imaging, diagnostic procedures, and other clinical findings. According to system Standard Operating Procedure (SOP) 6103.509, "Notification/View Alert Management," primary care providers must process view alerts within 7 days.¹

The assistant chief of primary care reported relying on a dashboard developed by the Veterans Integrated Service Network acting Chief Health Informatics Officer that showed alerts aged over 21 days. However, since November 2025, the chief of primary care implemented corrective actions, including reviewing a report daily to monitor alerts aged over 7 days or greater and providing verbal counseling when unprocessed view alerts exceeded 7 days.

EHR Documentation

Veterans Health Administration (VHA) Directive 1907.01(1), *VHA Health Information Management and Health Records*, requires primary care providers to complete progress notes within 7 calendar days of patient visits.² Leaders did not effectively monitor primary care provider compliance with EHR documentation requirements prior to July 2025. Without complete documentation, patient EHRs do not accurately reflect the care provided or any necessary follow-up actions, increasing patient safety risks.

¹ System SOP 6103.509, *View Alert Management*, January 28, 2022, rescinded and replaced by System SOP 6103.509, *Notification/View Alert Management*, February 26, 2025. The SOPs contain similar language related to processing view alerts within 7 days.

² VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023.

State Licensing Board Reporting

The OIG found that the System Director and credentialing and privileging manager did not initiate the state licensing board reporting process within 7 business days after a primary care provider was removed in late 2024 for not meeting accepted standards of practice, as required by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*.³ During the OIG site inspection in June 2025, facility leaders reported the primary care provider to the state licensing board, months after the primary care provider's removal. Timely reporting of providers who do not meet accepted standards of practice is critical to alert potential employers of concerns.

In spring 2026, the Interim System Director announced changes to system's executive leadership team. As of May 11, 2026, system leaders confirmed that there was an Interim System Director, Interim Deputy Medical Center Director, Interim Associate Director, Interim Chief of Staff, Acting Associate Director for Patient Care Services, and an Acting Assistant Director.

The OIG made one recommendation to the Veterans Integrated Service Network director related to training on state licensing board reporting requirements.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Service Network Director concurred with the findings and recommendation and provided an acceptable action plan to ensure relevant system leaders and staff are trained on state licensing board reporting requirements (see appendix A). The OIG will follow up on the planned actions until they are completed.



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³ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

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Abbreviations

AI	artificial intelligence
EHR	electronic health record
OIG	Office of Inspector General
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Augusta Health Care System (system) in Georgia. The OIG evaluated whether system leaders maintained oversight of primary care providers' management of electronic health record (EHR) view alerts and completion of documentation following patient visits. The inspection occurred from May 12, 2025, through January 28, 2026, with an on-site visit from June 24 through 26, 2025. Following the on-site visit, virtual interviews continued through January 20, 2026.

Background

The system is part of Veterans Integrated Service Network (VISN) 7, the VA Southeast Network, and operates two campuses located in Augusta, Georgia. The system has community-based outpatient clinics in Athens and Statesboro, Georgia; and Aiken, South Carolina.

The Veterans Health Administration (VHA) classifies the system as level 1b, indicating high complexity.¹ From October 1, 2024, through September 30, 2025, the system served 52,899 patients and offered a wide variety of inpatient and outpatient services, including primary care.

View Alerts

View alerts are notifications sent through the EHR to providers, including primary care providers, that communicate information such as results of laboratory tests, diagnostic imaging, diagnostic procedures, and other clinical findings. View alerts may prompt further primary care provider action, for example, signing an order or addressing abnormal results (such as high blood sugar values) before they reach a critical level that could result in hospitalization.² To process a view alert, primary care providers open the alert, which is then automatically deleted.

Prior OIG Reports

The OIG published a report on July 1, 2021, that included two findings related to unprocessed view alerts and one finding related to patient visits without progress notes and recommended the System Director

- ensure a policy defines the required time frame for providers to process view alerts (closed February 17, 2022),

¹ VHA Office of Productivity, Efficiency, & Staffing (OPES), "Facility Complexity Model Fact Sheet," October 1, 2023. The Facility Complexity Model categorizes VHA facilities at levels 1a, 1b, 1c, 2, or 3. A level 1b facility has "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs."

² VA Office of Information and Technology, Computerized Patient Record System (CPRS) User Guide: GUI Version, May 2025.

- continue to monitor providers' compliance with processing view alerts and evaluate the effectiveness of the corrective actions to reduce unnecessary view alerts (closed January 3, 2022), and
- ensure the chief of Health Information Management Services monitors EHR documentation to include patient visits without progress notes (closed January 3, 2022).³

Allegations and Related Concerns

In fall 2024, a complainant alleged a system primary care provider (subject primary care provider) had thousands of unprocessed view alerts and was not completing required progress notes following patient visits. The OIG sent a case referral to the System Director, who substantiated the allegations. The System Director removed the subject primary care provider from employment in late 2024.

As the subject primary care provider was the focus of the 2021 OIG report, the OIG opened an inspection on May 12, 2025, to assess whether

- system leaders monitored system primary care providers' required processing of view alerts and completion of required progress notes following patient visits and took corrective actions as appropriate, and
- system leaders initiated the state licensing board reporting process timely after removing the subject primary care provider from employment.⁴

Scope and Methodology

The OIG interviewed the complainant on May 29, 2025, and conducted a site visit from June 24 through 26, 2025. The OIG interviewed VISN, system, and primary care leaders, as well as other leaders and staff knowledgeable on the topics related to this inspection.⁵ Virtual interviews continued through January 20, 2026. Documents reviewed for this inspection covered the period from March 1, 2022, through January 28, 2026.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on

³ VA OIG, [Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia](#), Report No. 20-00354-178, July 1, 2021.

⁴ VA OIG, [Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia](#); VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁵ The OIG interviewed the VISN Director, Chief Medical Officer, and credentialing and privileging program officer. The OIG also interviewed the System Director and Chief of Staff.

Integrity and Efficiency's standards.⁶ During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspections teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."⁷

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG 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

View Alerts Oversight

The OIG found that, prior to this inspection, primary care and system leaders were not providing effective oversight of view alerts. However, after assuming the role in July 2025, the chief of primary care implemented effective oversight of view alerts.

According to system Standard Operating Procedure (SOP) 6103.509, "*Notification/View Alert Management*," primary care providers must process view alerts within 7 days.⁸ VHA

⁶ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁷ Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-21-21: § 4(a), April 3, 2025.

⁸ System SOP 6103.509, "View Alert Management," January 28, 2022, rescinded and replaced by System SOP 6103.509, "Notification/View Alert Management," February 26, 2025. The SOPs contain similar language related to processing view alerts within 7 days.

Directive 1907.01(1) and system SOP 6103.509 assign service chiefs the responsibility for monitoring and ensuring providers process view alerts timely.⁹

During interviews, system leaders acknowledged that primary care provider view alert processing times often exceeded 21 days. The assistant chief of primary care reported relying on a VISN 7 dashboard report that displayed primary care provider view alerts aged greater than 21 days. When asked how the standard of 21 days was created, the VISN acting Chief Health Informatics Officer explained that system Chief Health Informatics Officers decided to report view alerts aged greater than 21 days, rather than the required 7 days, after reviewing data and understanding that there were individuals who received several alerts daily.

Through email correspondence and an interview, the OIG learned that on July 14, 2025, a permanent chief of primary care assumed the position after it had remained vacant for 28 months. Through interviews, the OIG learned that in November 2025, the chief of primary care reviewed a report daily that the primary care administrative officer created that identified unprocessed view alerts aged 7 days or greater. Using the report, the chief of primary care initiated corrective actions for view alerts that remained unprocessed beyond 7 days. These actions included verbal counseling and requiring primary care providers to meet with information technology staff for training on view alert management.

The OIG concluded that, prior to the appointment of the chief of primary care, primary care leaders did not effectively monitor the required processing of view alerts.¹⁰ Following the appointment, the chief of primary care established a process to monitor unprocessed view alerts aged more than 7 days and implemented corrective actions as necessary in alignment with VHA Directive 1907.01(1) and SOP 6103.509.¹¹

EHR Documentation Oversight

The OIG found that prior to July 2025, primary care leaders and a Health Information Management Services leader did not effectively monitor whether primary care providers documented progress notes within 7 days of a patient's visit. Without complete documentation, patient EHRs do not accurately reflect the care provided or any necessary follow-up actions, increasing patient safety risks. Furthermore, the chief of Health Information Management

⁹ VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023.; System SOP 6103.509. The SOPs contain similar language related to service chief monitoring of view alerts.

¹⁰ VHA Directive 1907.01(1).

¹¹ VHA Directive 1907.01(1); System SOP 6103.509.

Services did not consistently report the status of patient visits without progress notes to the Health Information Management Committee as required by VHA Directive 1907.01(1).¹²

VHA Directive 1907.01(1) requires primary care providers to complete progress notes within 7 calendar days of a patient visit.¹³ The chief of primary care is “responsible for management of the clinical content of health records for” primary care providers under their supervision.¹⁴ The chief of Health Information Management Services “[conducts] audits and monitors to ensure accurate ... timely and complete” EHR documentation.¹⁵

The acting chief and assistant chief of primary care told the OIG they faced challenges obtaining reports with the necessary information to monitor individual primary care provider’s documentation of progress notes. The chief of Health Information Management Services acknowledged being responsible for tracking EHR documentation but reported not monitoring or sharing reports of patient visits without progress notes with primary care leaders or primary care providers.

The assistant chief of primary care reported that, since July 2025, a deputy chief of Health Information Management Services began sending primary care leaders a daily report containing information needed to monitor primary care providers’ completion of required progress notes. During an interview, the chief of primary care explained using the report to ensure primary care providers completed progress notes within 7 days. In December, the chief of primary care provided the OIG with data showing that the system had only one primary care patient visit without a progress note over 7 days old.

VHA Directive 1907.01(1) requires the chief of Health Information Management Services to report EHR documentation completion to the Health Information Management Committee.¹⁶

The OIG reviewed minutes from 18 Health Information Management Committee meetings held during the review period and found that EHR documentation of patient visits without progress notes was discussed only at the March 2022 meeting, shortly after the OIG closed the 2021 OIG

¹² VHA Directive 1907.01(1). In December 2022, the Health Information Management Committee replaced the Medical Records Committee. For the purposes of this report, the OIG refers to both committees as the Health Information Management Committee.

¹³ VHA Directive 1907.01(1).

¹⁴ VHA Directive 1907.01(1).

¹⁵ VHA Directive 1907.01(1).

¹⁶ VHA Directive 1907.01(1).

report recommendations.¹⁷

In a September 2025 email exchange, when the OIG asked the chief of Health Information Management Services why data regarding patient visits without progress notes had not been reported at the Health Information Management Committee since March 2022, the chief of Health Information Management Services responded that the reports were not relevant to the committee members, as the committee only consisted of Health Information Management Services staff and did not discuss work to resolve EHR documentation of patient visits without progress notes. In a December 2025 email, the chief of Health Information Management Services told the OIG, and the OIG confirmed through review of meeting minutes, that reporting on EHR documentation of patient visits without progress notes at the Health Information Management Committee occurred in September 2025.

The OIG concluded that prior to September 2025, the chief of Health Information Management Services had not regularly reported information regarding patient visits without progress notes at the Health Information Management Committee or Operations Council. However, in September 2025, this information was included in the Health Information Management Committee minutes.

State Licensing Board Reporting

VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, requires credentialing and privileging managers to initiate the state licensing board reporting process within 7 business days of the supervisor's identification of provision of care concerns on an exit review form.¹⁸

The OIG reviewed documentation and found the subject primary care provider's supervisor completed an exit review form on the subject primary care provider's final day of employment, documenting that the subject primary care provider did not meet "generally accepted standards of practice as to raise reasonable concern for safety of patients." However, the System Director did not ensure that the credentialing and privileging manager initiated the state licensing board reporting process within 7 business days as required.¹⁹ The state licensing board reporting

¹⁷ VA OIG, *Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia*. The System Director's response to the report addressed actions to include ensuring Health Information Management Committee reporting included the EHR review process and mandated monthly reports. Since March 2021, the Health Information Management Committee was responsible for reporting completion of EHR documentation. As of December 2022, the Health Information Management Committee became responsible for tracking and oversight of documentation of patient visits without progress notes.

¹⁸ VHA Directive 1100.18.

¹⁹ VHA Directive 1100.18.

process was initiated during the OIG site visit in June 2025, several months after the credentialing and privileging manager had received the exit review form.²⁰

In interviews with the OIG, both the credentialing and privileging manager and the System Director justified the delay by stating incorrectly that state licensing board reporting could not occur until the subject primary care provider had an opportunity to appeal an adverse personnel action.

During the site visit, the VISN Chief Medical Officer informed the OIG of having responsibility for oversight of facility credentialing and privileging. Both the VISN Chief Medical Officer and the VISN credentialing and privileging officer told the OIG they were aware of the subject primary care provider's removal from VHA employment and state licensing board reporting requirements.²¹ Following the visit, the VISN credentialing and privileging officer reported the state licensing board reporting process was initiated.

The OIG concluded that the System Director's and credentialing and privileging manager's lack of understanding of reporting requirements contributed to the delay in initiating reporting the subject primary care provider to the state licensing board.²² Furthermore, although aware of the reporting requirements, the VISN Chief Medical Officer and VISN credentialing and privileging officer did not ensure the System Director and credentialing and privileging manager initiated timely reporting. Timely reporting of providers who do not meet accepted standards of practice is critical to alert potential employers of concerns.

Conclusion

The OIG concluded that deficiencies in primary care, system, and VISN oversight, as well as committee reporting, contributed to noncompliance with VHA policies. Prior to November 2025, primary care and system leaders did not effectively monitor view alerts or ensure required completion of progress notes for patient visits, resulting in noncompliance with VHA Directive 1907.01(1). Contrary to system SOP 6103.509 requiring action within 7 days, oversight practices relied on an incorrect metric that showed when view alerts were older than 21 days.

Starting in November 2025, the chief of primary care implemented corrective actions for view alerts that remained unprocessed beyond 7 days, in alignment with VHA Directive 1907.01(1) and SOP 6103.509.

Prior to July 2025, primary care leaders and a Health Information Management Services leader did not effectively monitor completion of progress notes for patient visits, but monitoring was

²⁰ The acting System Director completed state licensing board reporting on July 21, 2025.

²¹ VHA Directive 1100.18.

²² VHA Directive 1100.18. State licensing board reporting must not wait until personnel actions have been completed.

corrected to include information needed for effective oversight. As of December 2025, the chief of primary care reported only one primary care patient visit without a progress note.

Further, prior to September 2025, the chief of Health Information Management Services had not regularly reported documentation of patient visits without progress notes at the Health Information Management Committee. However, in September 2025, this information was included in the Health Information Management Committee minutes.

Finally, the OIG determined that neither the credentialing and privileging manager nor the System Director initiated state licensing board reporting in accordance with VHA Directive 1100.18. The VISN Chief Medical Officer and the VISN credentialing and privileging officer did not ensure timely reporting.

In spring 2026, the Interim System Director announced changes to the system's executive leadership team. As of May 11, 2026, system leaders confirmed that there was an Interim System Director, Interim Deputy Medical Center Director, Interim Associate Director, Interim Chief of Staff, Acting Associate Director for Patient Care Services, and an Acting Assistant Director.

The VISN Director concurred with the findings and recommendation and provided acceptable action plans to ensure relevant system leaders and staff are trained on state licensing board reporting requirements.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendation

The Veterans Integrated Service Network 7 VA Southeast Network Director ensures relevant system staff and leaders are trained on state licensing board reporting requirements to include timeliness of reporting.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 17, 2026

From: Acting Director, Department of Veterans Affairs (VA) Veterans Integrated Service Network 7
(VISN 7) Southeast Network (10N07)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) Report, Review of Primary
Care Providers' Completion of Electronic Health Record Documentation at the VA Augusta Health
Care System in Georgia

To: Director, Office of Healthcare Inspections (54HL09)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Review of Primary Care Providers' Completion of Electronic Health Record Documentation at the VA Augusta Health Care System in Georgia. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. VA Southeast Network concurs with the recommendation and will take corrective action
2. I have reviewed the documentation and concur with the response as submitted.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. Should you have any questions or require further information, please contact the Veterans Integrated Service Network (VISN 7) Quality Management Officer.

(Original signed by:)

Benita K. Miller, FACHE, LISW-CP

[OIG comment: The OIG received the above memorandum from VHA on April 20, 2026.]

VISN Director Response

Recommendation

The Veterans Integrated Service Network 7 VA Southeast Network Director ensures relevant system staff and leaders are trained on state licensing board reporting requirements to include timeliness of reporting.

Concur

Nonconcur

Target date for completion: July 2026

Director Comments

The Veterans Integrated Service Network (VISN) 7 Department of Veterans Affairs Southeast Network Director will ensure relevant system staff and leaders are trained on State Licensing Board (SLB) reporting requirements as they relate to both current and former employees to include timeliness of reporting.

The VISN 7 Credentialing and Privileging (C&P) Officer provided refresher training to the C&P Manager in June and July 2025 on the SLB reporting process and required timelines. This included training on the National Veterans Health Administration Privileging Action/SLB/National Practitioner Data Bank Tracker.

The VISN C&P Officer will train relevant system staff and leaders on the SLB reporting process as they relate to both current and former employees and required timelines during the annual VISN 7 Chief Medical Officer site visit scheduled for June 2026. The VISN Quality and Patient Safety Committee will monitor staff trained and compliance.

OIG Contact and Staff Acknowledgments

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