Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-04038-521

Healthcare Inspection

Alleged Suicides and Inappropriate Changes to Mental Health Treatment Programs Coatesville VA Medical Center Coatesville, Pennsylvania

September 30, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations that two suicides may have occurred following the early termination of case management services, and two suicides may have occurred with the closure of a sub-acute psychiatric inpatient ward at the Coatesville VA Medical Center, (facility) in Coatesville, PA.

The complainant also alleged that:

- The management decision to close a sub-acute psychiatric inpatient ward was made without regard to patient safety.
- The consolidation of two Domiciliary Care for Homeless Veterans (DCHV) units did not follow Veterans Health Administration (VHA) policy.
- The admission criteria to the DCHV were too restrictive.
- The management decision to close the Community Transition and Wellness Center did not follow VHA policy.

We did not substantiate that any patient suicides occurred due to early termination of case management or the closure of a sub-acute psychiatric inpatient ward. We found that the facility complied with VHA policy when it closed the beds on the ward. We did not substantiate that the changes were made without regard to patient safety.

We did not substantiate that the consolidation of two DCHV units violated VHA policy. We substantiated the allegation that admission criteria to the DCHV program were restrictive; however, the issue was identified during a VHA site visit conducted November 8, 2012, and corrected.

We substantiated that the facility's decision to close the Community Transition and Wellness Center violated VHA policy. We found that the facility did not transition the Community Transition and Wellness Center program to a Psychosocial Rehabilitation and Recovery Center as required by VHA policy. We recommended that the Facility Director coordinate with VHA leadership regarding the establishment of a Psychosocial Rehabilitation and Recovery Center.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 10–12 for the Directors' comments.) 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 that two suicides may have occurred following the early termination of case management services, and two suicides may have occurred with the closure of a sub-acute psychiatric inpatient ward at the Coatesville VA Medical Center, (facility) in Coatesville, PA. The OIG also assessed allegations that the facility did not follow Veterans Health Administration (VHA) guidelines in closing or modifying other mental health care programs.

Background

The facility is a 452-bed specialty referral, transitional care, and neuropsychiatric facility that includes inpatient bed programs that provide medical, psychiatric, and nursing home care. The facility has 229 residential rehabilitation and treatment (RRTP) beds and provides specialized care in geriatrics, substance abuse, post-traumatic stress, and women's health. Three community-style living programs for discharged veterans are operated on the grounds of the facility. The facility served 19,477 veterans and had 222,871 outpatient visits in fiscal year (FY) 2014 and is part of Veterans Integrated Service Network (VISN) 4.

Domiciliary Care for Homeless Veterans (DCHV). The DCHV was established through legislation passed in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. Domiciliary care was initially established to provide services to economically-disadvantaged veterans and has evolved from a "Soldiers' Home" to become an active clinical rehabilitation and treatment program for male and female veterans. Domiciliary programs are now integrated with the Mental Health Residential Rehabilitation and Treatment Program (MH RRTP).[1]

MH RRTP. VHA's MH RRTPs provide a 24-hour therapeutic setting for veterans utilizing professional and peer support in a structured environment to treat substance abuse, post-traumatic stress disorder, and other mental health conditions.[2] Patients in MH RRTPs can also seek treatment in intensive outpatient programs.

Community Transition and Wellness Center. Community Transition and Wellness Centers (CTWCs) provide treatment for patients with serious mental illness (SMI)[3] in an outpatient stabilization center to manage chronic symptoms and assist veterans to avoid re-hospitalization. In FY 2011, VHA directed that facilities convert these programs to Psychosocial Rehabilitation and Recovery Centers (PRRC).[4]

[1] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program.* December 22, 2010.
[2] VHA Handbook 1162.02.
[3] American Psychiatric Association Diagnostic and Statistical Manual (DSM) (4th Ed. 201X). SMI is a disorder resulting in significant functional impairment and disruption in major activities of daily living. Schizophrenia and bipolar disorder are frequently labeled as SMI because of the can cause significant disruption of an individual's daily life.
[4] VHA Handbook 1163.03, *Psychosocial Rehabilitation and Recovery Centers (PRRC),* July 1, 2011.

PRRC. PRRCs are outpatient transitional learning centers designed to support recovery and integration into the community for veterans with SMI and severe functional impairment. Programming is curriculum-based and is specifically designed to teach the requisite skills that assist the veteran in achieving individual goals and integrating into the community.[5]

Housing First. Housing First is a VHA approach to ending homelessness for the most vulnerable and chronically homeless individuals. The Housing First model prioritizes housing and then assists the veteran with access to healthcare and other supports that promote stable housing and improved quality of life. The model does not try to determine who is "housing ready" or demand treatment prior to housing. Instead, treatment and other support services are provided as the veteran obtains and maintains permanent housing.[6]

Allegations

In July 2013, the OIG Office of Healthcare Inspections received a complaint that two suicides may have occurred following the early termination of case management. During an interview, the complainant alleged that there may have been two additional suicides related to the closure of a sub-acute psychiatric inpatient ward (Unit 58A). The complainant also alleged that:

- Management's decision to close Unit 58A was made without regard to patient safety.
- Consolidation of DCHV Units 7A and 7B did not follow VHA policy.
- Admission criteria to the DCHV were too restrictive.
- Management's decision to close the CTWC did not follow VHA policy.

Scope and Methodology

We conducted site visits in October 2013 and January 2014 and completed data gathering in February 2015. Prior to our site visits we interviewed the complainant. While onsite, we interviewed the Director, Chief of Staff, Chief Nurse Executive, the Associate Chief of Mental Health Services, the Mental Health Director, Chief of Social Work, the prior Director of Mental Health Nursing Services, nurse managers, nursing staff, psychologists, social work staff, physician assistants, and physicians.

[5] VHA Handbook 1163.03.
[6] See VA National Center on Homelessness of Veterans at http://www.endveteranhomelessness.org/programs/housing-first-pilot. Accessed April 8, 2015. The program combines VA and Housing of Urban Development resources to provide vouchers for Veterans to rent privately-owned housing, and support through VA case management services that include health care, mental health treatment, vocational assistance, and job development.

We reviewed VHA and local policies, meeting minutes, external consultant reports, e-mail messages, VISN and VHA Issue Briefs, staffing data, and relevant medical literature. We also reviewed the electronic health records (EHRs) of the patients alleged to have committed suicide and 33 patients who were discharged from Unit 58A prior to its closure.

We did not address allegations related to labor relations and human resource issues or allegations that we were unable to clarify and/or for which we were unable to obtain specific information.

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: Suicides

We did not substantiate that patient suicides were caused by the early termination of case management or the closure of Unit 58A.

Patient 1

Patient 1 was a veteran in his mid-twenties who sustained a head injury during an overseas deployment. He began treatment at the facility in 2006. His diagnoses included post-traumatic stress disorder, paranoia, borderline personality and bipolar disorders, substance and alcohol dependence, and chronic homelessness. He was prescribed medication for depression. He was treated on Unit 58A and discharged in February 2011.

In June 2011, the patient was discharged from the facility after a short stay for drug and alcohol detoxification. The patient was treated by a psychiatrist during the hospitalization and denied any suicidal ideation. One week later he was found unconscious by a friend, taken to a local non-VA community hospital Emergency Department (ED), admitted for care, treated for drug and alcohol overdose, examined by a psychiatrist, and discharged home 1 day later with instructions to follow up at the facility. Multiple attempts by VA case managers to contact the patient were unsuccessful. A case manager discussed the case with the psychiatrist, and the decision was made to discharge the patient from the "Supported Employment Program." Approximately 1 week after the non-VA ED visit, the patient was seen at the facility and treated by a psychiatrist. The patient had a blood alcohol level of .06; he was offered a change in treatment from Mental Health Intensive Case Management to Substance Abuse Disorder (SUD) inpatient treatment but reluctantly agreed only to SUD outpatient treatment. He stated "you shouldn't worry about me. I will be OK" and denied any suicidal ideation. His EHR was "flagged" as high risk for suicide.[7] The primary purpose of a flag is to communicate to staff that a veteran is at high risk for suicide and presence of the flag should be considered when making treatment decisions.

Over the next several days, facility staff placed five unsuccessful phone calls to the patient to coordinate outpatient SUD treatment and check on his well-being. Twelve days after the visit to the facility psychiatrist noted above, the Mental Health Intensive Case Management case manager and her supervisor went to the patient's apartment, where they noted the patient's car was in the parking lot, but there was no response at the door or to phone calls placed. Later that day, the facility was notified that the patient had been found dead in his home.

[7] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. This Directive has expired and has not yet been re-certified. See also, VHA Directive 2010-053, *Patient Record Flags,* December 3, 2010. This Directive discusses patient record flags for behavior and clinical issues.

Patient 2

Patient 2 was a male in his forties whose service included an overseas deployment. He had a history of drug and alcohol abuse dating back to the 1990s. He sought care at the VA in 2001 for borderline personality disorder, post-traumatic stress disorder, bi-polar disorder, alcohol dependence, cocaine use, liver disease related to alcohol abuse, homelessness, and joblessness. He had active prescriptions to control and treat anxiety, agitation, and depression.

In June 2011, the patient was discharged from the facility after a short stay for drug and alcohol detoxification. He had follow-up appointments the next week with dental, primary care, and mental health; he kept his dental and mental health appointments. His EHR was "flagged" as high risk for suicide. The patient was a "no-show" (did not come and did not cancel) for his post-discharge day 9 SUD appointment but was treated at the urgent care department and was "noticeably intoxicated." The patient refused admission and was discharged in the care of his roommate. He returned the next day to the Suicide Prevention Coordinator's office, "was visibly intoxicated," sat down for a few minutes, and left as his "ride was waiting for him." He was seen in Primary Care on post-discharge day 10, where inpatient SUD was offered and refused, and the patient denied any suicidal ideation. On post-discharge day 16, he was seen by a psychiatrist, again refused inpatient SUD, and denied suicidal ideation. His EHR was "flagged" for another 90 days.

For the next 10 days there are no entries in the EHR. On post-discharge day 28, the patient missed a scheduled mental health appointment, and a phone call was placed and voicemail left for the patient. Two days later, the patient's case manager was notified that the patient had committed suicide.

Patient 3

Patient 3 was a female in her thirties. She began her treatment at the facility in 2007 when she was treated for bipolar disorder and a history of drug and alcohol abuse in sustained remission. Her recent diagnoses included a history of schizophrenia, recurrent suicidal ideations, psychotic disorder, and personality disorder. She had active prescriptions to control and treat anxiety and psychosis. She had not been a patient on Unit 58A, as the complainant alleged, but was admitted to Unit 58B in January 2012, for a drug overdose in an attempt to end her life. She was discharged 2 days later to be followed by Mental Health Intensive Case Management. Her EHR was "flagged" as a high risk for suicide.

She continued to be followed by the Mental Health Intensive Case manager until April when she was discharged from this program due to multiple missed appointments. She was reassigned to a new case manager who continued to meet with her at least weekly. She continued to be "flagged" as a high risk for suicide.

In May, 2012, the patient was seen by a psychiatrist for a routine mental health appointment. Medication for treatment of psychosis was discontinued, and she was

given a 7-day supply of other medications. There were no safety concerns, and she denied depression. Her record continued to be "flagged" as high risk for suicide.

Five days later, she was seen by the case manager. According to the EHR, she "presented as pleasant and easily engaged in conversation." Two days after the case manager's visit, she called and cancelled an appointment with the case manager due to transportation problems. Later the same day, she called the facility Urgent Care Center stating, "I have jaundice and I am turning yellow. I also have lost 30 pounds." The Registered Nurse she spoke with directed her to come to the Urgent Care Center.

The next day, the case manager spoke with the patient regarding a personal matter at home. Later that day, case managers stopped by to check on the patient. She did not appear jaundiced and had not lost 30 pounds, as she had reported to the nurse the day before. There "was nothing amiss" at her home. The case manager spoke with the patient again later that day. That evening, an ambulance was called to the patient's home because the patient was having seizures. When emergency staff arrived they found the patient restrained by the local police and having intermittent seizures. The EHR noted that the patient stated she had taken approximately 60 pills but did not state what they were. She was treated for the seizures but became unresponsive as she was loaded into the ambulance. She was transported to a non-VA community hospital, and upon arrival she went into cardiac arrest. She was successfully resuscitated but experienced multi organ failure and was unresponsive.

A few days later the patient died. The facility was notified of the patient's death the same day.

Patient 4

The complainant was unable to provide the identity of the fourth patient who was alleged to have committed suicide. We were unable to identify any patients who reasonably matched the complainant's allegations.

The three patients whose EHRs we reviewed were appropriately treated and followed by facility staff. The suicides were immediately reviewed by the facility and briefed to the VISN.

Issue 2: Unit 58A Bed Closures

We did not substantiate that the facility violated VHA policy when patients were transferred from Unit 58A to other units and treatment programs, as these treatment programs met patient needs. We found that the facility coordinated with the VISN on the unit changes and received VISN approval to make changes to the unit. We did not substantiate that the changes were made without regard to patient safety.

VHA policy for inpatient bed changes provides guidance for VISNs in the development and approval of bed change proposals. VHA tracks bed change requests that require Deputy Under Secretary for Health for Operations and Management approval, while facilities and VISNs that propose changes are responsible for collaborating and

consulting with appropriate program officials prior to submitting bed change proposals. This ensures that changes are consistent with VHA Mental Health program policy, workload projections, clinical practice guidelines, and compliance with bed change/closure requirements.[8]

The facility's bed change initiative aligned with VHA's mandate to transform the facility from a chronic long-term inpatient care facility to one that utilizes a recovery first outpatient continuum of care.[9] In October 2011, the facility changed the focus of the DCHV units from a "Housing Ready" to a "Housing First" model. This resulted in a continual decrease in the average daily census of the sub-acute inpatient psychiatry unit by providing patients with housing first and then focusing on their treatment needs.[10]

In January 2011, the facility provided sub-acute inpatient psychiatric care on Unit 58A, a 38-bed unlocked unit. By February, the psychiatry staff had analyzed the patients and staffing levels on the unit, concluded that there was a steady declining census, and recommended that the unit be closed. The Facility Director concurred with the review and requested VISN guidance. In March 2011, the VISN approved the facility request to reduce the number of inpatient beds.

In November 2012, VHA approved closure of 23 beds on the unit with 15 beds to remain open for at least 6 months to ensure that the inpatient mental health census would not increase requiring use of the remaining beds. The 6-month review was submitted by the facility in August 2013 along with a request to close the remaining 15 beds.

We visited the unit in October 2013 and found the unit was used to store excess equipment and supplies, and we were informed that unit staff had been reassigned throughout the facility. Facility staff reported that they monitored the inpatient psychiatry census daily and that the census had not approached a level where the beds on the unit would be needed. The facility was unable to provide a plan for reopening the unit should the need arise.

We reviewed the EHRs of the 33 patients who were on the unit during February and March 2011 and found that they were appropriately discharged to outpatient care at the facility or elsewhere and that no patient was lost to follow-up. We did not identify any suicides or clusters of suicides that were associated with the closure of the unit, mental health programmatic changes, or the early termination of case management services.

[8] VHA Directive 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010.
[9] VHA Handbook 1162.02.
[10] The United States Substance Abuse and Mental Health Services Administration defines recovery as a journey of healing that allows a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. See http://www.samhsa.gov/, accessed April 15, 2015.

Issue 3: DCHV Units 7A and 7B

We did not substantiate the allegation that the consolidation of DCHV Units 7A and 7B violated VHA policy, as the action was not a reduction or restructure of a major clinical program or service. We substantiated the allegation that admission criteria to the DCHV program were restrictive; however, the issue was identified during a VHA site visit and corrected.

DCHV Consolidation

In October 2011, the facility notified the VISN that three DCHV units were being consolidated into two DCHV units. The rationale for the consolidation was that facility efforts to end veteran homelessness, through the Housing First Initiative, had led to an extended period of low occupancy in the DCHV resulting in a decreased demand for homeless domiciliary beds.

DCHV Admission Criteria

VHA policy requires the facility to develop admission policies that reduce barriers to admission to the Domiciliary Residential Rehabilitation Treatment Programs.[11] The Domiciliary Chief (MH RRTP) position was vacant from 2009 through 2013. During this period, decisions affecting the MH RRTP were made by the Associate Chief, Mental Health Services and the Director of Mental Health for Nursing. In May 2011, a facility committee was formed to discuss initiating a Housing First model. The committee expressed concern that admission to the DCHV Housing First model was too restrictive in that they required patients admitted to the DCHV to be employment ready with a stated goal of permanent employment. The committee recommended conducting a Housing First pilot; however, mental health leadership declined the recommendation.

In November 2012, a review by VHA of the DCHV and Housing First program found that the facility had made significant changes to the program. That review found that these changes could improve the likelihood that a patient would be discharged to independent housing; however, the changes were not consistent with VHA policy and resulted in reduced access to needed services for a subset of homeless veterans. In December 2012, the facility DCHV admission criteria were relaxed to permit more admissions rather than attempt to move some homeless veterans directly into a community housing arrangement.

Issue 4: CTWC Closure

We found that the facility did not transition the CTWC program to a PRRC as required by VHA policy.[12] The facility operated a CTWC for SMI and dual diagnosis patients; however, the facility made a decision to close the program due to a lack of patient participation and heavy staff involvement.

[11] VHA Directive 1162.02.
[12] VHA Handbook 1163.03

VHA guidance issued in FY 2011 required:

- Facilities with 1,500 or more current patients included on the National Psychosis Registry to have a PRRC.

- Facilities currently having day treatment centers, day hospitals, partial hospitals, or analogous programs to transform their existing programs into PRRCs.

The facility submitted waiver requests to VHA in FYs 2011 and 2012 requesting to not convert the CTWC into a PRRC. As of February 2015, the facility had not received a response from VHA regarding their request not to establish a PRRC. We found that although the facility did not meet the population threshold that required them to establish a PRRC, they failed to meet the requirement to convert the CTWC to a PRRC and closed the CTWC.

Conclusions

We did not substantiate that the early termination of case management services or the closure of a sub-acute psychiatric inpatient ward (Unit 58A) resulted in patient suicides. We found that the facility complied with VHA policy when they closed the beds on Unit 58A. We did not substantiate that the changes were made without regard to patient safety.

We did not substantiate that the consolidation of DCHV units 7A and 7B violated VHA policy or that DCHV admission criteria violated VHA policy. We substantiated the allegation that admission criteria to the DCHV program were restrictive; however, the issue was identified during a VHA site visit and corrected. We substantiated that the facility's decision to close the CTWC and not convert to a PRRC violated VHA policy.

Recommendation

1. We recommended that the Facility Director coordinate with Veterans Health Administration leadership regarding the establishment of a Psychosocial Rehabilitation and Recovery Center.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: June 18, 2015

From: Director, VA Healthcare – VISN 4 (10N4)

Subj: Draft Report: Healthcare Inspection— Alleged Suicides and Inappropriate Changes to Mental Health Treatment Programs, Coatesville VA Medical Center, Coatesville, Pennsylvania

To: Director, Washington DC Office of Healthcare Inspections (54DC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the response provided by the Coatesville VA Medical Center and am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Quality Management Officer, 412-822-3294.

(original signed by:)

Carla Sivek

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 17, 2015

From: Director, Coatesville VA Medical Center, Coatesville, PA (542/00)

Subj: Draft Report: Healthcare Inspection—Alleged Suicides and Inappropriate Changes to Mental Health Treatment Programs, Coatesville VA Medical Center, Coatesville, Pennsylvania

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General Healthcare Inspection of Coatesville VA Medical Center. I concur with the findings outlined in this report and have included the corrective action plan.

2. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(original signed by Jonathan Eckman, P.E., Associate Director for:)

Gary W. Devansky
Medical Center Director

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the Facility Director coordinate with Veterans Health Administration leadership regarding the establishment of a Psychosocial Rehabilitation and Recovery Center.

Concur

Target date for completion: June 30, 2016

Facility response: Thank you for the opportunity to review the draft report titled, Healthcare Inspection-Alleged Suicides and Inappropriate Changes to Mental Health Treatment Programs, Coatesville VAMC, Coatesville, PA. Leadership welcomes the opportunity to develop and establish a PRRC on the Coatesville campus. This program will include written policies detailing the mission and programming specifics.

The PRRC program will be located in a dedicated space in the basement of Building 7. This space includes five offices and one large group room. Small and large groups can be accommodated in this area. The large group room will contain a resource library, computer connection, and can serve as a waiting room area. The second floor of Building 7 also has a Day Room, which will also be dedicated to the PRRC program. The kitchen on the second floor will be used for independent living skills training.

Our staffing requirements are based on the National Psychosis Registry data, which indicates a decline in those Veterans who would be identified as potential participants. Leadership has determined that given this decline, the PRRC programming will demand 16 dedicated hours per week. The PRRC staff assigned to this program would dedicate 20 hours per week to accommodate staff meetings, screening, treatment planning and program development and enhancement. The staffing that will be dedicated to the PRRC program includes 1.0 Peer Counselor/Support Specialist, 1.0 Social Worker, and 0.25 Psychologist. Additional services will participate in the program include, but not limited to, Chaplaincy, Occupational Therapy, Recreational Therapy, Dietician, Pharmacy, Kinesiology, and Licensed Professional Mental Health Coordinator. Existing staff resources are sufficient to meet the needs of the Veterans that are expected to participate in the initial start of the PRRC program. The facility dedicated psychologist, in consultation with the director for Outpatient Psychosocial Rehabilitation & Recovery Services, will develop the programming specifics and PRRC policy by December 14, 2015.

No additional funding is needed at this time. No construction contracts or remodeling is anticipated as the program will utilize the existing facility spaces. The opening date of the PRRC program is scheduled for February, 15, 2016.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Gail Bozzelli, RN, Team Leader Lisa Barnes, MSW Donna Giroux, RN Alan Mallinger, MD Julie Kroviak, MD Randall Snow, JD Natalie Sadow, MBA

Appendix D

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