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Healthcare Inspection

Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center

July 17, 2017

Washington, DC 20420

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Table of Contents

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the October 2014 request of Congressman Timothy J. Walz to assess quality of care concerns at the St. Cloud VA Health Care System (St. Cloud System), St. Cloud, MN; the Minneapolis VA Health Care System (Minneapolis System), Minneapolis, MN; and the St. Paul Veterans Readjustment Counseling Center (Vet Center), New Brighton, MN. Specifically, the areas of concern were:

St. Cloud System

- System managers notified patients through a letter rather than individual contact when they decided to stop covering mental health (MH) services provided by a non-VA Post-Traumatic Stress Disorder (PTSD) clinic in 2009.
- When system managers stopped authorizing services through a non-VA PTSD provider, veterans were left without MH services.

Minneapolis System

- System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2014.
- A patient's colonoscopy was not scheduled timely.
- A patient's radiographic examination (x-ray) of the foot was not scheduled timely.
- A patient did not receive test results timely.
- A provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed.

Vet Center

- When the Vet Center contract for non-VA PTSD care was terminated, a Vet Center staff member misled and was dishonest with the vendor regarding delays versus termination and was disingenuous [pretended to show concern] about patients' care.
- Vet Center patients rejected the alternative PTSD services offered, and patients were left without MH treatment.

We received other allegations that we excluded from review due to the remote time frame during which patients received care or because the allegation lacked sufficient details to permit the review and/or was not within the purview of the Office of Healthcare Inspections.

In 2009, St. Cloud System managers reportedly sent a letter to patients who were receiving non-VA PTSD care. The letter informed patients that authorization for MH

services would be discontinued and that PTSD care was available at either the St. Cloud or Minneapolis Systems.

We substantiated that St. Cloud System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2009. Following this decision, St. Cloud staff did not individually contact or assess patients' clinical statuses; evaluate patients' personal treatment preferences and needs; plan for further treatment; or implement adequate processes for terminating or transferring patients in accordance with the VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.[1]

We substantiated that when St. Cloud System managers stopped authorizing services through non-VA PTSD providers, 7 of the 18 identified veterans did not seek or receive MH services from VA. However, we were unable to determine if those veterans who did not receive VA MH services obtained alternative MH care in the private sector.

In 2014, Minneapolis System managers reportedly notified patients through a letter that they had decided to stop covering MH services provided by a non-VA PTSD clinic. We substantiated that Minneapolis System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic. However, the decision to stop covering non-VA PTSD MH services was rescinded approximately 3 months after sending notification letters. Patients did not experience a break in the non-VA PTSD MH services.

We could not substantiate that when the Vet Center contract for non-VA PTSD care was terminated in 2014, a Vet Center staff member misled and was dishonest with the vendor regarding delays versus termination and disingenuous [pretended to show concern] about patients' care. The VISN 23 Contracting Officer informed us that the Vet Center contracted with a non-VA provider for provision of PTSD care from October 1, 2008, through September 30, 2013. We reviewed emails dated October 3, 2013, and December 18, 2013, from the VISN 23 contracting officer[2] informing the non-VA provider the contract had not been renewed or extended. On April 17, 2014, the VISN 23 contracting officer informed the non-VA provider that a new contract for non-VA PTSD care had not been granted. We were unable to evaluate the Vet Center staff member's concern for patients' care. During interviews in February 2015, we were informed that the Vet Center staff member had retired. In an effort to assess the Vet Center's concern for patients, we evaluated staff attempts to contact patients regarding termination of non-VA PTSD services. We did not find documentation that Vet Center staff successfully contacted all affected patients to arrange for transfer back to the Vet Center or VA MH services.

[1] VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Center*, September 11, 2008, amended November 16, 2015. This VHA Handbook was scheduled for recertification September 30, 2013 and has not yet been recertified.
[2] The VISN 23 Contracting Office was the point of contact for the contract between the Vet Center and a non-VA PTSD provider group.

We did not substantiate that alternative MH care was rejected by the Vet Center's 20 patient care documents we reviewed and that these patients were left without MH care and services. We found that 14 of the 20 patients continued to receive MH care through non-VA services, the Vet Center, or VHA, and 4 continued to receive medical care through VHA. We were unable to determine if the remaining 2 patients who did not receive VA MH services received MH care in the private sector.

We did not substantiate that a patient's colonoscopy was not scheduled timely at the Minneapolis System. We identified documentation that the patient had colonoscopy screenings in accordance with VHA guidelines. We made no recommendation.

We substantiated that a patient's x-ray of his foot was not scheduled timely at the Minneapolis System in 2014. The x-ray was not completed until approximately 2½ months after it was ordered. A Minneapolis System Quality Manager acknowledged the scheduling inconsistencies and provided documentation that Minneapolis System managers subsequently implemented processes to monitor outpatient schedulers to ensure appointments are made timely.

We substantiated that test results were not communicated timely to a patient by his provider at the Minneapolis System. We found that a patient had a magnetic resonance imaging of the spine in 2013 and was not informed of the results until 63 days later. We did not find documentation that the patient experienced adverse effects due to untimely communication of his test results. A Minneapolis System Quality Manager acknowledged that patients were not receiving test results timely. Minneapolis System managers developed an action plan to ensure patients receive test results in accordance with VHA policy.

We substantiated that a provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed. We found that a patient was taking a blood thinner and a non-steroidal anti-inflammatory agent. When taken simultaneously, the medications could increase a patient's risk of bleeding. However, we found no documentation that the patient experienced adverse drug interactions. A Minneapolis System Quality Manager acknowledged the medication reconciliation inconsistencies, and Minneapolis System managers have identified problems and opportunities for improvement to ensure medication reconciliation is done consistently in the outpatient setting. We made no recommendation.

We recommended that the:

- St. Cloud VA Health Care System Director incorporate processes to ensure assessment of patient preference, plans for further treatment, and an adequate process for termination or transfer to VHA mental health services when non-VA mental health services are discontinued.

- St. Cloud VA Health Care System Director identify patients whose non-VA post-traumatic stress disorder services were terminated as discussed in this

report, determine if the patients were offered and received mental health treatment, and take action as appropriate.

- Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration scheduling policies.

- Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration communication of test results policies.

- Chief Officer, Readjustment Counseling identify St. Paul Vet Center patients whose non-VA post-traumatic stress disorder services were terminated as discussed in this report, determine if the patients were offered and received mental health services, and take action as appropriate.

Comments

The VISN Director, System Directors and Chief Officer, Readjusting Counseling Services concurred with our recommendations and provided acceptable action plans. (See Appendixes A, B, C, and D, pages 17–23 for the Directors' and Chief Officer's comments.) We consider Recommendations 1, 3, and 4 closed and will follow up on the planned actions for the remaining recommendations until completed.

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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the October 2014 request of Congressman Timothy J. Walz to assess quality of care concerns at the St. Cloud VA Health Care System (St. Cloud System), St. Cloud, MN; the Minneapolis VA Health Care System (Minneapolis System), Minneapolis, MN; and the St. Paul Veterans Readjustment Counseling Center (Vet Center), New Brighton, MN.

Background

Description of Facilities

St. Cloud System. The St. Cloud System provides outpatient primary care, minor surgery, urgent and specialty care, inpatient acute psychiatric and outpatient mental health (MH) care, extended and rehabilitative care, and three community based outpatient clinics (CBOC). The St. Cloud System is part of Veterans Integrated Service Network (VISN) 23 and serves over 38,000 unique patients.

Minneapolis System. The Minneapolis System provides a broad range of inpatient and outpatient medical, surgical, MH, specialty care, and 13 CBOCs located throughout Minnesota and Western Wisconsin. Six of the 13 CBOCs are contract CBOCs that are operated by non-VA healthcare providers. The Minneapolis System is part of VISN 23 and serves more than 100,000 unique patients.

Mankato CBOC. The Mankato CBOC is part of the Minneapolis System. The Mankato CBOC is a contract CBOC, and the clinic has a mix of VA and non-VA staff. The CBOC provides primary care, women's health, MH, and MH video teleconferencing.[3] Point-of-care laboratory testing and general radiographic examinations (x-ray) are also available at the clinic.[4] The Mankato CBOC serves over 3,700 unique patients.

Vet Center. The Vet Center is a Veterans Readjustment Counseling Services Vet Center, a community based facility where counseling and outreach are provided to combat veterans and their families.[5] The mission of Veterans Readjustment Counseling Services is to help combat veterans and their families readjust to post-war civilian life.[6] Veterans Readjustment Counseling Services programs rely on VA medical facilities for support with fiscal, human resources, contracting, acquisition, and engineering service

[3] Video teleconferencing is a health information technology system that uses cameras and video equipment to facilitate real-time face-to-face interactions between providers and patients.
[4] Point-of-care testing is laboratory testing done at the site of patient care; specimens are analyzed and results are provided during the patient visit.
[5] VHA Directive 1500.01, *Readjustment Counseling Services (RCS) Vet Center Program,* September 8, 2010. This VHA Directive was scheduled for recertification on or before the last working day of September 2015 and has not yet been recertified.
[6] Ibid.

functions.[7] Services are confidential and patient records are maintained separately from VHA health care facilities and systems.[8]

The Vet Center, located in New Brighton, MN, offers individual and group counseling Monday through Saturday. Minneapolis and St. Cloud System patients may receive post-traumatic stress disorder (PTSD) services at the Vet Center. In fiscal year (FY) 2014, the Vet Center provided 2,789 counseling visits to 321 unique patients.

PTSD Description and Treatments

Description. According to the 2010 *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress (Guideline):*

> *PTSD is a clinically significant condition with symptoms continuing more than 1 month after exposure to a trauma that has caused significant distress or impairment in social, occupational, or other important areas of functioning.*[9]
>
> *Patients with PTSD may exhibit persistent re-experiencing of the traumatic event(s), persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness (not present before the trauma), and persistent symptoms of increased arousal (not present before the trauma).*[10]

The Guideline further states that:

> *PTSD can appear alone (presenting with common symptoms of PTSD) or more commonly with other co-occurring conditions (persistent difficulties in interpersonal relations, mood, chronic pain, sleep disturbances, somatization, and profound identity problems) or psychiatric disorder*.[11]

Evidence-Based Psychotherapy. Psychotherapy involves talking with a psychiatrist, psychologist, or other MH provider.[12] According to the Guideline:

> *Psychotherapy interventions are aimed at reduction of symptoms severity, improving global functioning, and improvement in quality of life and functioning in social and occupational areas. Evidence-based psychotherapeutic interventions for PTSD that are most strongly supported by RCTs [randomly controlled trials]… include… Prolonged*

[7] VHA Directive 1500.01, *Readjustment Counseling Services (RCS) Vet Center Program,* September 8, 2010.
[8] Ibid.
[9] *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress,* October 2010.
[10] Ibid.
[11] Ibid.
[12] Mayo Clinic Psychotherapy Overview. "Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health provider." http://www.mayoclinic.org/tests-procedures/psychotherapy/home/ovc-20197188. Accessed June 15, 2016.

> *Exposure Therapy, Cognitive Processing [Therapy]… and Eye movement Desensitization and Reprocessing. …Psychoeducation is another important component of all interventions.*[13]

VHA Handbook 1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics (Handbook)*[14], requires evidenced-based psychotherapies to be available to patients diagnosed with PTSD.

Supportive Groups. The Guideline[15] describes supportive groups as generally present-focused. Supportive groups focus on current life issues rather than traumatic experiences, and the aim of the groups is to enhance daily functioning through provision of safety, trust, acceptance, and normalization of symptoms and experiences. Supportive groups also aim to help patients develop mastery over problems via group feedback, emotional support, and reinforcement of adaptive behaviors.

Course of Therapy/Treatment Termination. When patients demonstrate remission from PTSD symptoms, and further therapy is no longer indicated, the Guideline recommends the therapist consider discontinuation of psychotherapeutic treatment.[16] The Guideline further recommends a gradual step-down approach to treatment termination may be warranted if patients experience anxiety as a result of the discontinuation process. The step-down approach to treatment termination includes changing the type of therapy, reducing the frequency of therapeutic visits, and/or reducing medication dosages.

The Handbook[17] states:

> *The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. No longstanding supportive groups are to be discontinued without consideration of patient preference, planning for further treatment, and the need for an adequate process of termination or transfer.*

Non-VA Care. Non-VA medical care, formerly known as "fee basis care," is a program that authorizes veteran medical centers and health care systems to purchase medical

[13] *VA/DoD Clinical Practice Guideline For Management of Post-Traumatic Stress,* October 2010.
[14] VHA Handbook 1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015. This VHA Handbook was scheduled for recertification September 30, 2013 and has not yet been recertified.
[15] *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress*, October 2010.
[16] Ibid.
[17] VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

and MH care (including psychological services) from providers who are not affiliated with, or employed by, VA health care facilities.[18]

Allegations

In October 2014, OIG received a request from Congressman Timothy J. Walz to review quality of care concerns at the St. Cloud System, Minneapolis System, and Vet Center. Specifically, the areas of concern were:

St. Cloud System

- System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2009.
- When system managers stopped authorizing services through the non-VA PTSD provider, veterans were left without MH services.

Minneapolis System

- System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2014.
- A patient's colonoscopy was not scheduled timely.
- A patient's radiographic examination (x-ray) of the foot was not scheduled timely.
- A patient did not receive test results timely.
- A provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed.

Vet Center

- When the Vet Center contract for non-VA PTSD care was terminated, a Vet Center staff member misled and was dishonest with the vendor regarding delays vs termination and disingenuous [pretended to show concern] about patients' care.
- Vet Center patients rejected the alternative PTSD services offered, and no other option was made available.

[18] VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013, outlines the services that are covered by the non-VA care program.

Scope and Methodology

We conducted our review from October 2014 through April 2016. We conducted a site visit at the Minneapolis System and the Mankato CBOC December 3–5, 2014.

We telephonically interviewed the following St Cloud System staff:

- Chief and the then-Chief of MH Services
- MH Coordinator
- MH Services contracting officer
- MH care provider
- Non-VA medical care coordinator at the St. Cloud System

During our site visit, we interviewed the following Minneapolis System staff:

- Chief of MH Services
- Acting Chief of Neurology
- Chief of Neurosurgery
- MH Liaison
- MH Coordinator
- Non-VA medical care coordinators
- Contracting officers for the Minneapolis System

We interviewed the Mankato CBOC's primary care physicians (PCPs), nurse manager, and clinical staff. We interviewed the Vet Center's Team Leader, Regional Manager, and a counselor. We also interviewed a VISN 23 Contracting Officer and non-VA PTSD providers.

We received multiple lists of patients whose non-VA PTSD services were allegedly terminated. After accounting for duplicates, we identified 115 unique patients. We excluded 10 patients, as their care was remote in time, and the allegations lacked sufficient details to permit the review or were not within the purview of the Office of Healthcare Inspections. We reviewed electronic health records (EHRs) of the remaining 105 patients as detailed below:

1. We reviewed the EHRs of three patients whose names were provided to us at the time we received the original allegations.

   Two of the three patients were also on either the list of Minneapolis patients or Vet Center patients provided by the complainant. (See Item 3 and/or 4 below.) Both patients are discussed in relation to Issue 1 of this report. The non-MH related medical care for the remaining patient is addressed in Issue 2.

2. We reviewed the EHRs of 18 patients who received care at the St. Cloud System.[19]

3. We reviewed the EHRs of 64 patients who received care at the Minneapolis System.[20]

4. We reviewed care documents for 20 patients identified as Vet Center clients.

We reviewed the Guideline;[21] VHA Directive 2007-004, *Colorectal Cancer Screening,*[22] local Minneapolis System policies for medication reconciliation; VHA Directive 2009-019, *Ordering and Reporting Test Results;*[23] and other relevant documents. We reviewed quality management documents for the Minneapolis System. We reviewed written correspondence between a non-VA PTSD provider and the St. Cloud and Minneapolis System Directors. We also reviewed contracts between the Vet Center and a non-VA MH provider group.

Four of the VHA policies cited in this report were expired or beyond their recertification dates and have not been updated:

1. VHA Directive 1500.01, *Readjustment Counseling Services (RCS) Vet Center Program,* September 8, 2010 (recertification due date September 30, 2015).

2. VHA Handbook 1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015 (recertification due date September 30, 2013).

3. VHA Directive 2006-041, *Veterans Health Care Service Standards- Corrected Copy*, June 27, 2006 (expired June 30, 2011).

4. VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011 (expired March 31, 2016).

We considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy

[19] Three of the 18 patients had expired. The patients' EHRs did not contain evidence that the patients died from MH-related conditions. .
[20] Three of the 64 patients had expired. The patients' EHRs did not contain evidence that the patients died from MH-related conditions. .
[21] The 2010 VA/DOD, *Clinical Practice Guideline for the Management of Post-Traumatic Stress*, provides clinical guidance for managing patients with post-traumatic stress disorder.
[22] VHA Directive 2007-004, *Colorectal Cancer Screening*, dated January 12, 2007, was current at the time of the events discussed in this report. However, the Directive was rescinded December 2014 and replaced by VHA Directive 1015, *Colorectal Cancer Screening*, dated December 30, 2014.
[23] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009, was current at the time of the events discussed in this report. However, the Directive was rescinded October 2015 and replaced by VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

provided by VHA Directive 6330(1),[24] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[25] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[26]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is 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.

[24] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[25] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[26] Ibid.

Inspection Results

Issue 1: Termination of Authorization for Non-VA PTSD Care

A. St. Cloud System

Notification of Termination of Non-VA MH Services

We substantiated that St. Cloud System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2009. Following this decision, St. Cloud staff did not individually contact or assess patients' clinical statuses; evaluate patients' personal treatment preferences and needs; plan for further treatment; or implement adequate processes for terminating or transferring patients in accordance with the VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.[27]

We were told that St. Cloud System managers sent a letter to patients who were receiving non-VA PTSD care. The letter informed patients that authorization for MH services would be discontinued and that PTSD care was available at either the St. Cloud or Minneapolis Systems. The letter did not state when the non-VA PTSD care would terminate. We did not find documentation of notification letters in the EHRs that we reviewed. A copy of the letter was also sent to a non-VA PTSD provider.

We reviewed documentation that a non-VA PTSD provider expressed concerns on January 27, 2010, to the St. Cloud System managers regarding what the provider considered as "unethical" termination of PTSD care. The non-VA PTSD provider requested that St. Cloud System managers reconsider their decision to terminate the non-VA PTSD care. On February 23, 2010, St. Cloud System managers informed the provider that the decision to discontinue authorizations for non-VA PTSD care would not be reversed.

A St. Cloud System MH provider told us that authorizations were denied for ongoing treatment with a non-VA provider because patients were not making progress. The provider expressed his perception that the non-VA PTSD provider was not providing evidence-based PTSD therapy and did not always work to get people to function at their highest level. He also stated that VA was offering evidence-based therapy for the treatment of PTSD.

The MH provider further stated he reviewed patient progress notes from a non-VA PTSD provider as part of his decision-making process that resulted in the discontinuance of authorizations for non-VA PTSD care; however, given the passage of time since the reviews, he could not recall how extensively he reviewed the progress

[27] VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Center*, September 11, 2008.

notes. He stated that he was not confident the patients received ongoing care after the termination of the non-VA PTSD care.

Veterans Left Without MH Services

We substantiated that when St. Cloud System managers stopped authorizing services through non-VA PTSD providers, some veterans did not seek or receive MH services from VA. However, we were unable to determine if those veterans who did not receive VA MH services obtained alternative MH care in the private sector.

To evaluate whether veterans were left without MH services, we reviewed the EHRs of all 18 patients who received non-VA PTSD care that was authorized and then terminated by the St. Cloud System. We identified documentation that the care was discontinued. However, we did not find documentation addressing consideration of patient preference, planning for further treatment, or the presence of an adequate process of termination or transfer. We found 3 of the 18 patients had expired. The patients' EHRs did not contain evidence that the patients died from MH-related conditions. Eight patients received MH services through either the St. Cloud System or the Minneapolis System. We did not find documentation that the remaining seven patients sought or received VA MH services after non-VA PTSD care was discontinued.

B. Minneapolis System

Authorization for Non-VA PTSD Services

We substantiated that Minneapolis System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2014. However, the decision to stop covering non-VA PTSD MH services was rescinded approximately 3 months after sending notification letters, and prior to the decision's effectiveness date. Accordingly, no patient experienced a break in access to non-VA PTSD MH services.

We reviewed a letter dated May 13, 2014, in which the Minneapolis System MH Chief informed a non-VA PTSD provider that authorizations for non-VA PTSD care would be discontinued as of September 30, 2014. Patients were also mailed a letter from the Minneapolis System Chief of MH Services that authorizations would be discontinued and PTSD care would be available at the Vet Center and the Mankato CBOC.

The Minneapolis System Chief of MH Services told us the rationale for terminating authorization of non-VA PTSD care was that PTSD services were available through the Minneapolis System. This decision aligned with the Minneapolis System managers' intention to bring patients back into the Minneapolis System for PTSD care. In addition, the Minneapolis System offered evidenced-based psychotherapies that aligned with VHA's focus on a rehabilitative model of MH care. The Chief of MH services determined that returning patients to the system aligned with the patients' clinical needs.

A non-VA PTSD provider stated to us that while he understood the Minneapolis System managers' emphasis on evidence-based psychotherapies and metrics of improvement,

some patients struggled to "keep their heads above water." This non-VA PTSD provider asserted, for these patients, there may not be markers/evidence of improvement, but long-standing PTSD groups provide benefit by maintaining a level of function for these patients who would otherwise diminish to a non-functional level in the absence of the supportive groups.

Approximately 3 months after sending notification letters, Minneapolis System managers decided to continue authorizing the non-VA PTSD care due to concerns that patients could not access VA care. The non-VA PTSD provider was informed of this change via a letter dated August 1, 2014, prior to the previously determined September 30, 2014, discontinuation date. Therefore, authorization for the non-VA PTSD was ultimately not discontinued, and patients did not experience a break in the non-VA PTSD services.

We reviewed the EHRs of 64 patients identified as receiving authorizations for non-VA care through the Minneapolis System. We found 3 of the 64 patients had expired. The patients' EHRs did not contain evidence that the patients died from MH-related conditions. The remaining 61 patients continued to receive PTSD care from a non-VA provider.

C. Vet Center

Termination of Non-VA Contract

We could not substantiate that when the Vet Center contract for non-VA PTSD care was terminated, a Vet Center staff member misled and was dishonest with the vendor regarding delays vs termination and disingenuous [pretended to show concern] about patients' care. The VISN 23 Contracting Officer informed us that the Vet Center contracted with a non-VA provider for the provision of PTSD care from October 1, 2008 through September 30, 2013. We reviewed emails dated October 3, 2013 and December 18, 2013 from the VISN 23 contracting officer[28] informing the non-VA provider the contract had not been renewed or extended. Additionally, on April 17, 2014, the VISN 23 contracting officer informed the non-VA provider that a new contract for non-VA PTSD care had not been granted.

We were unable to evaluate the Vet Center staff member's concern for patients' care. During interviews in February 2015, we were informed that the Vet Center staff member had retired. In an effort to assess the Vet Center's concern for patients, we evaluated staff attempts to contact patients regarding termination of non-VA PTSD services.

A Vet Center counselor informed us he/she attempted to contact and inform 12 patients that the Vet Center would no longer authorize the non-VA PTSD care they were receiving from a contracted provider. The counselor provided documentation that

[28] The VISN 23 Contracting Office was the point of contact for the contract between the veteran and a non-VA PTSD provider group.

he/she met with 5 patients, spoke with 2 patients, emailed 1 patient, and left a voice mail for 4 patients.

We were also provided documentation from another source that Vet Center staff informed 11 patients that authorizations for non-VA care would be discontinued and alternative services would be offered (5 veterans remained at New Brighton Vet Center, 5 veterans indicated they would seek services in the future, and one veteran went to a non-VA provider). However, the names of the patients referenced in this documentation were not provided and the Vet Center could not clarify if the patients were different from or inclusive of the patients who the Vet Center counselor attempted to contact. We did not find documentation that Vet Center staff successfully contacted all affected patients to arrange for transfer back to the Vet Center or VA MH services.

Alternative MH Care

We did not substantiate that 20 Vet Center patients whose care documents we reviewed rejected the alternative PTSD services offered, and no other option was made available. In addition to reviewing non-EHR Vet Center documentation related to the patients who had formerly received PTSD care through a non-VA provider and/or for whom the Vet Center had a record of documented contact, we also searched Minneapolis and St. Cloud System EHRs to ascertain if any Vet Center patients had received MH care at either location. We found 20 Vet Center patients and determined the following:

- Three of the 20 patients were authorized to receive PTSD care from a non-VA provider. One of the three patients was simultaneously receiving PTSD care at the Vet Center.

- Three of the remaining 17 patients were receiving PTSD care from the Vet Center. Two of the three patients were simultaneously receiving MH care at the Minneapolis System. Of the two patients receiving care at the Vet Center and Minneapolis System, one patient discontinued care with the Vet Center in February 2014.

- Three of the remaining 14 patients received MH care at the St. Cloud System.

- Three of the remaining 11 patients received MH care at the Minneapolis System.

- Two patients transferred care to Sioux Falls, SD. We found documentation that one patient was receiving MH care; however, we did not find documentation that one patient was receiving MH care.

- We were unable to locate two patients in the St. Cloud or Minneapolis Systems or as being seen at the Vet Center.

- The remaining four patients were receiving medical care from the St. Cloud and/or Minneapolis Systems, but we did not find that these four patients were receiving MH care.

Issue 2: Timeliness of Scheduling a Colonoscopy

We did not substantiate that a patient's colonoscopy was not scheduled timely at the Minneapolis System. According to VHA Directive 2007-004, *Colorectal Cancer Screening*, persons not at high risk for developing colorectal cancer should have a colonoscopy at least every 10 years.[29,30]

The patient was considered to be at high risk for developing colorectal cancer. The patient had a normal colonoscopy in 2009, and the gastroenterologist recommended a follow-up colonoscopy in 5 years (2014). Approximately 6 months prior to the 5-year due date during a primary care visit at the Mankato CBOC, the patient requested a colonoscopy stating he was due to have the screening. The PCP completed a consult for a routine colonoscopy, which was scheduled and completed in 2014.

Issue 3: Timeliness of Scheduling a Radiographic Examination

We substantiated that a patient's x-ray of his left foot was not scheduled timely at a Minneapolis System CBOC. According to VHA Directive, patients must be able to schedule an appointment for a routine diagnostic test within 30 days referral.[31] A scheduler is responsible for scheduling an appointment on or as close to the desired date as possible. If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment timeframe.[32]

In 2014, the patient telephoned the Mankato CBOC staff and requested an x-ray, stating he had broken his toes about a month ago. The next day, the PCP acknowledged and approved the request for the x-ray that was ordered to be completed on the day of, or 1 day prior to the veteran's next appointment. We found documentation that CBOC staff acknowledged receipt of the provider's order. We did not find documentation of a scheduled clinic appointment or an appointment for a foot x-ray.

We found documentation that approximately 2½ months later, the patient transferred care to another Minneapolis CBOC, where the patient received an x-ray of his left foot.

[29] VHA Directive 2007-004, *Colorectal Cancer Screening*, dated January 12, 2007, was current at the time of the events discussed in this report; it was rescinded December 2014 and replaced by VHA Directive 1015, *Colorectal Cancer Screening*, December 30, 2014.
[30] Persons with a personal history of inflammatory bowel disease, polyps, and/or who had a parent, sibling, or child diagnosed with colorectal cancer, are considered at high risk for developing colorectal cancer.
[31] VHA Directive 2006-041, *Veterans Health Care Service Standards- Corrected Copy*, June 27, 2006.
[32] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, revised December 8, 2015, was current at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1230, *VHA Outpatient Scheduling Processes and Procedures*, July, 2016. VHA Directive 1230 updates procedures for consult processes and establishes the use of consult business rules.

The x-ray identified a fracture of the fourth toe. Four days after the x-ray was done, the PCP sent the patient a letter informing him of imaging results and instructions for care.

We found that Minneapolis System managers did not consistently audit outpatient appointment schedulers to ensure appointments are scheduled timely at CBOCs. A Minneapolis System Quality Manager acknowledged the inconsistency and provided documentation that Minneapolis System managers subsequently implemented processes to monitor outpatient appointment schedulers to ensure appointments are made timely.

Issue 4: Delay in Communicating Test Results

We substantiated that a patient's test results were not communicated timely by a Minneapolis System provider. According to VHA Directive 2009-019, *Ordering and Reporting Test Results,*[33] and Minneapolis System policy, abnormal test results were to be reported to patients no later than 14 days from the date the results are available to the ordering practitioner. We found that a patient had a magnetic resonance imaging (MRI) of his back that revealed bulging discs[34] in 2013. The radiologist verified the MRI report the same day.

The patient requested the results on day 31, day 51 and day 57 post-MRI, but was not informed of the results until day 63. We did not find documentation why the provider did not inform the patient of his test results until day 63 post-MRI. We did not find documentation that the patient experienced adverse effects related to untimely communication of his test results.

We found Minneapolis System managers identified that patients were not receiving test results in accordance with VHA and Minneapolis System policies. A Minneapolis System Quality Manager acknowledged that patients were not receiving test results timely and Minneapolis System managers developed an action plan to ensure patients receive test results in accordance with VHA policy.[35]

Issue 5: Changing Medications Without Considering Adverse Interactions

We substantiated that a provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed. According to VHA Directive 2011-012, *Medication Reconciliation,*[36] providers are required to complete a medication reconciliation at every episode of care when

[33] VHA Directive 2009-019, *Ordering and Reporting Test Results*, dated March 9, 2011, was current at the time of the events discussed in this report. However, the Directive was rescinded October 2015 and replaced by VHA Directive 1088, *Communicating Test Results to Providers and Patients*, dated October 7, 2015.
[34] Bulging discs are a medical condition of the spine in which the inner portion of a spinal disc protrudes and places pressure on nerve roots causing pain that can radiate down a person's back.
[35] VHA Directive 2009-019.
[36] VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.

medications are administered, prescribed, or modified to minimize the potential safety risk to patients.[37]

The allegation did not include the specific names of the medications with potentially significant adverse interactions. We reviewed the patient's EHR and identified that the patient was simultaneously taking a blood thinner provided by a non-VA provider and a non-steroidal anti-inflammatory agent (NSAIA A) ordered by VA providers.

In 2014, the patient's VA PCP prescribed the NSAIA A to be taken twice daily by mouth. We also noted that the patient was taking the blood thinner prescribed by a non-VA provider when the NSAIA A was ordered and a medication reconciliation was not completed during the visit. We reviewed a pharmacy note, that identified NSAIA A and the blood thinner that had been ordered as having the potential for a moderate to significant drug-drug interaction.[38] Specifically, the combination of these medications may increase a patient's risk of bleeding.

Approximately 2 weeks later, a medication reconciliation was completed and the two medications were discontinued. We did not find documentation the patient experienced adverse medication interactions.

We reviewed documentation that system providers did not consistently perform outpatient medication reconciliation. A Minneapolis System Quality Manager acknowledged the inconsistency, and that Minneapolis System managers had identified problems and opportunities for improvement to ensure medication reconciliation is done consistently in the outpatient setting.

Conclusions

We substantiated that St. Cloud System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2009. Following this decision, St. Cloud staff did not individually contact or assess patients' clinical statuses; evaluate patients' personal treatment preferences and needs; plan for further treatment; or implement adequate processes for terminating or transferring patients.[39]

We substantiated that when St. Cloud System managers stopped authorizing services through non-VA PTSD providers, some veterans did not seek or receive MH services from VA. However, we were unable to determine if those veterans who did not receive VA MH services obtained alternative MH care in the private sector.

[37] VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
[38] Drug-drug interactions may occur when two or more drugs react with each other and cause unintended side-effects.
[39] VHA Handbook1160.01, *Uniformed Mental Health Services in VA Medical Center*, September 11, 2008.

We substantiated that Minneapolis System managers notified patients through a letter rather than individual contact when they decided to stop covering MH services provided by a non-VA PTSD clinic in 2014. However, the decision to stop covering non-VA PTSD MH services was rescinded approximately 3 months after sending notification letters, and prior to the decision's effectiveness date. Accordingly, no patient experienced a break in access to non-VA PTSD MH services.

We could not substantiate when the Vet Center contract for non-VA PTSD care was terminated in 2014, a Vet Center staff member misled and was dishonest with the vendor regarding delays versus termination and disingenuous [pretended to show concern] about patients' care. We were unable to evaluate the Vet Center staff member's concern for patients' care. During interviews in February 2015, we were informed that the Vet Center staff member had retired. In an effort to assess the Vet Center's concern for patients, we evaluated staff attempts to contact patients regarding termination of non-VA PTSD services. We did not find documentation that Vet Center staff successfully contacted all affected patients to arrange for transfer back to the Vet Center or VA MH services.

We did not substantiate that 20 Vet Center patients rejected the alternative PTSD services offered, and no other option was made available. We found that 14 of 20 patients continued to receive MH care through non-VA services, the Vet Center or VHA and four continued to receive only medical care through VHA. We were unable to determine if the remaining 2 patients who did not receive VA MH services received MH care in the private sector.

We did not substantiate that a patient's colonoscopy was not scheduled timely. We identified documentation that the patient had colonoscopy screenings in accordance with VHA guidelines. We made no recommendation.

We substantiated that a patient's x-ray of his foot was not scheduled timely. The x-ray was completed approximately 2½ months after it was ordered. A Minneapolis System Quality Manager acknowledged the inconsistency and told us the Minneapolis System managers subsequently implemented processes to monitor outpatient schedulers to ensure appointments are made timely.

We substantiated that test results were not communicated timely to a patient by his provider at the Minneapolis System. We found that a patient had a magnetic resonance imaging of the spine in 2013, and was not informed of the results until 63 days later. We did not find documentation that the patient experienced any adverse effects due to untimely communication of his test results. A Minneapolis System Quality Manager acknowledged that patients were not receiving test results timely and Minneapolis System managers developed an action plan to ensure patients receive test results in accordance with VHA policy.

We substantiated that a provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed. We found that a patient was taking a blood thinner and NSAIA A. When taken

simultaneously, the medications increase a patient's risk of bleeding. However, there was no documentation that the patient experienced any adverse drug interactions and the patient did not express concerns regarding his medications. A Minneapolis System Quality Manager acknowledged the inconsistency, and Minneapolis System managers have identified problems and opportunities for improvement to ensure medication reconciliation is done consistently in the outpatient setting. We made no recommendation.

Recommendations

1. We recommended that the St. Cloud VA Health Care System Director incorporate processes to ensure assessment of patient preference, plans for further treatment, and an adequate process for termination or transfer to VHA mental health services when non-VA mental health services are discontinued.

2. We recommended that the St. Cloud VA Health Care System Director identify patients whose non-VA Post-Traumatic Stress Disorder services were terminated as discussed in this report, determine if the patients were offered and received mental health treatment, and take action as appropriate.

3. We recommended that the Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration scheduling policies.

4. We recommended that the Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration communication of test results policies**.**

5. We recommended that the Chief Officer, Readjustment Counseling identify St. Paul Vet Center patients whose non-VA Post-Traumatic Stress Disorder services were terminated as discussed in this report, determine if the patients were offered and received mental health services, and take action as appropriate.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 2, 2017

From: Director, VA Midwest Health Care Network (10N23)

Subj: **Healthcare Inspection**—Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center

To: Director, Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the Healthcare Inspection-Quality of Care Concerns at Minneapolis VA HCS and St. Cloud VA HCS within Veterans Integrated Service Network 23. I concur with the action plans.

(original signed by:)
Janet P. Murphy

Appendix B

St. Cloud System Director Comments

Department of Veterans Affairs

Memorandum

Date: April 27, 2017

From: Director, St. Cloud VA Health Care System (656/00)

Subj: **Healthcare Inspection**—Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center

To: Director, VA Midwest Health Care Network (10N23)

1. I have reviewed and concur with the findings and recommendations in the healthcare inspection report.

2. I appreciate the opportunity for this review. Thank you.

(original signed by Cheryl Thieschafer *for:)*
STEPHEN D. BLACK

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 St. Cloud VA Health Care System Director incorporate processes to ensure assessment of patient preference, plans for further treatment, and an adequate process for termination or transfer to VHA mental health services when non-VA mental health services are discontinued.

Concur

Target date for completion: October 31, 2017

Facility response: The current non-VA care referrals process followed at the St. Cloud VAHCS mirrors guidelines set forth in the VA Care in the Community (Non-VA Purchased Care) and use of the Veterans Choice Memorandum published May 12, 2015, and updated October 1, 2015. The health care system will perform a retrospective review from September 2015 through April 2017 to determine if the current non-VA care referrals process ensures assessment of patient preference, plans for further treatment, and a process for termination or transfer to VHA mental health services when non-VA mental health services are discontinued and will adjust the processes as needed to meet the recommendations will be completed by May 19, 2017. Ongoing compliance will be monitored through a 100% audit of all Mental Health non-VA care referrals through the end of FY17.

Recommendation 2. We recommended that the St. Cloud VA Health Care System Director identify patients whose non-VA Post-Traumatic Stress Disorder services were terminated as discussed in this report, determine if the patients were offered and received mental health treatment, and take action as appropriate.

Concur

Target date for completion: Completed

Facility response: The health care system will audit the associated patient records from this report and determine if the patients were offered and received mental health treatment, and take actions as appropriate.

OIG Comment: Based on information provided, we consider this recommendation closed.

Appendix C

Minneapolis System Director Comments

Department of Veterans Affairs

Memorandum

Date: April 24, 2017

From: Director, Minneapolis VA Health Care System (618/00)

Subj: **Healthcare Inspection—**Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center

To: Director, VA Midwest Health Care Network (10N23)

1. Thank you for the opportunity to review the Healthcare Inspection report from December 3–5, 2014, site visit.

2. I have reviewed MVAHCS response to recommendations 3 and 4 and concur with the action plan.

3. Please feel free to contact me should you have additional questions.

(original signed by:)
Patrick J. Kelly, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 3. We recommended that the Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration scheduling policies.

Concur

Target date for completion: Closed (July 15, 2016)

Facility response: With the release of the updated VHA Directive 1230 "Outpatient Scheduling Processes and Procedures" on July 15, 2016, all Minneapolis VA staff Schedulers have been trained regarding expectations and scheduling changes to ensure adherence to VHA scheduling practices.

OIG Comment**:** Based on information provided, we consider this recommendation closed.

Recommendation 4. We recommended that the Minneapolis VA Health Care System Director ensure compliance with Veteran Health Administration communication of test results policies**.**

Concur

Target date for completion: Closed (September 2016)

Facility response: MVAHCS Chief of Staff convened a task force December 11, 2015, to examine and improve our process for managing results reporting to our patients based on the VHA Directive 1088 Communicating Test Results to Providers and Patients released on October 7, 2015. The task force, with the assistance of service line informatics, have developed and implemented a system in which laboratory data is reported to veterans by mail using an automated process. Specific to the issue noted in the report orthopedics MRI results reporting were tracked and audited by quality management staff to ensure compliance within the 7 and 14 day requirements in the directive. Please reference spreadsheet embedded below for the monthly audits for MRI results reporting. These audits were reported to the Compliance Committee and as of September 2016 we were at 97% compliance.

OIG Comment**:** Based on information provided, we consider this recommendation closed.

Appendix D

Chief Officer Readjustment Counseling Services Comments

Department of Veterans Affairs

Memorandum

Date: May 1, 2017

From: Chief Officer, Readjustment Counseling Services(10RCS)

Subj: **Healthcare Inspection—**Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center

To: Director, Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The Readjustment Counseling Service facility referenced in this report is the St. Paul, MN-Vet Center located at 550 County Road D West Suite 10, New Brighton, MN 55221.

2. The private sector provider was under contract with VA to provide readjustment counseling to Veterans referred by the Vet Center for combat theater PTSD. The contract expired on 9/30/2013 following 5 years of service as a readjustment counseling contract provider.

3. The contract provider held a contract with both the Vet Center and separately with the VAMC for fee basis care. Of the 20 patients, referenced on page 11 and being served by this contract, 12 were referred by the Vet Center for readjustment counseling. The status of the 12 Vet Center clients was reviewed on two different occasions. At the time the contract expired, the former Vet Center Team Leader, and COTR, contracted all 12 Veteran clients either in person or by telephone. Five (5) Veterans planned to consider services at the Vet center, six (6) Veterans indicated doing well with no plans to pursue services at the time, and one (1) Veteran indicated his plan to pursue services with the contractor pro bono.

4. At the request of representatives from the Chicago OIG Office in January 2015, the Vet Center, through the RCS regional Office, reopened its communication with the 12 Vet Center former Veteran clients of the contractor with the following results: two (2) Veterans were receiving care at the Vet

Center, two (2) Veterans were receiving pro bono counseling from the contractor, three (3) Veterans declined further services, four (4) Veterans did not respond to phone calls, and one (1) Veteran could not be located.

(original signed by:)

Michael W. Fisher, MSW

Comments to OIG's Report

The following Chief Officer, Readjustment Counseling comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 5. We recommended that the Chief Officer, Readjustment Counseling identify St. Paul Vet Center patients whose non-VA Post-Traumatic Stress Disorder services were terminated as discussed in this report, determine if the patients were offered and received mental health services, and take action as appropriate.

Concur

Target date for completion: June 30, 2017

Facility response: The Chief Readjustment Counseling Officer will take steps as indicated to ensure the 12 Vet Center clients are contacted again to determine their current service needs and to provide assistance to address needs as identified through the local Vet Center, referral to another Vet Center, or via referral to an appropriate provider.

The Chief Readjustment Counseling Officer will also take steps as indicated to provide national guidance to ensure that all Vet Center Directors, with contract for fee readjustment counseling programs, will notify their contract providers and referred Veteran clients in a timely manner about plans to terminate the contract to provide assistance to support appropriate timelines for transition and referral services.

Appendix E

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Alan Mallinger, MD Sheila Cooley, GNP, MSN Kathy Gudgell, RN JD Alicia Castillo-Flores, MBA, MPH Judy Brown, Management & Program Analyst

Appendix F

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