DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
CONNECTIONS TO CARE: IMPROVING SUBSTANCE USE DISORDER CARE
FOR VETERANS IN RURAL AMERICA AND BEYOND
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Chairman Tester, Ranking Member Moran, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Veterans Health Administration's (VHA) substance use disorder treatment programs in rural locations. The OIG's Office of Healthcare Inspections reviews the quality and safety of health care provided across VHA and communicates the findings through a variety of public reports. These include results from hotline inspections, national reviews, proactive comprehensive healthcare inspections, vet center inspections, and Veterans Integrated Service Network (VISN) reviews. For each of these reports, OIG clinical review teams provide recommendations for improving processes or further reducing risks to the veterans who entrust their health care to VA.

VHA faces significant challenges in meeting the complex needs of individuals with substance use disorders, and rural settings can pose additional obstacles in addressing those patients' needs. With more than three million veterans in rural and highly rural areas enrolled in VHA, the need for innovative and immediate healthcare access solutions for those veterans with substance use disorders is urgent.[1]

The devastating effects of substance use disorders on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health conditions that can place them at higher risk for suicide. Veterans living in highly rural areas are also 65 percent more likely to die from suicide that those residing in urban settings.[2] Given that VHA's top clinical priority is to reduce veteran suicide, timely access to evidence-based substance use disorder treatment programs is imperative to addressing the clinical needs of these high-risk patients.

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[1] VHA Office of Health Equity (OHE), "Access to Care among Rural Veterans" (fact sheet), March 10, 2020.

[2] VHA OHE, "Access to Care among Rural Veterans" (fact sheet), March 10, 2020.

The OIG reports highlighted in this testimony help to identify VHA challenges specific to providing veterans access to community care and coordination for high-risk patients. The risks to patient safety and care when either is deficient are significant and will only grow as VHA increases its reliance on community care providers. Recent OIG-collected data shows that in fiscal year (FY) 2022, more than 237,000 veterans enrolled at rural facilities have been referred for community care, including 7,400 for mental health treatment. The findings and recommendations in the highlighted reports that follow help underscore the need for (1) timely access to appropriate care, (2) oversight of VHA staff adherence to community care referral guidelines, and (3) care coordination and clinical information exchange between VHA and community care providers.

Our reports focus on issues relevant to leaders across the system in all settings—urban and rural. However, because of the inherent challenges of rural healthcare delivery, and the burdens these communities face in providing outreach and treatment to patients with mental health and substance use disorders, VHA and rural facility leaders must pay special attention when conducting risk assessments for these conditions. This statement focuses on a report involving a region of Texas to introduce key VHA requirements related to referrals for residential treatment for substance use. It also details a report that found substantial errors in the management of the care of a veteran undergoing alcohol withdrawal at the Tomah VA Medical Center, one of VA's rural facilities. While the findings from these reports are specific to one facility, they are intended to be reviewed and assessed across the system.

NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM

In August 2021, the OIG hotline received allegations that staff for the domiciliary substance use disorder treatment program (DOM SUD) at the VA North Texas Health Care System (VA North Texas) placed patients on waitlists for two to three months and failed to offer non-VA community residential care referrals for substance use disorder treatment.[3] The complainant also alleged that VA North Texas staff denied patients' requests for community residential care referrals, whereas patients from the Central Texas Veterans Health Care System in the same region (VISN 17), received community residential care treatment. During the OIG staff's review of the allegations [including examining 15 VA North Texas DOM SUD consults (referrals) and electronic health records for 10 patients], the team identified additional concerns related to compliance with required scheduling procedures and the assignment of mental health treatment coordinators to patients awaiting admission. To understand the context for the resulting report's findings, it is important to consider VHA's program goals and requirements.

[3] VA OIG, *Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System*, January 31, 2023.

Background

Mental health residential rehabilitation treatment programs (MH RRTPs) provide 24-hour treatment and rehabilitative services to patients with a range of needs and include domiciliary substance use disorder programs. MH RRTP is an umbrella term for a diverse group of residential programs that serve patients experiencing homelessness, substance use disorders, posttraumatic stress disorder, as well as other medical and mental health conditions. To be eligible for an MH RRTP referral, veterans must need a higher level of care than an outpatient program can provide but not be at imminent risk to themselves and others, and not meet criteria for a medical or acute mental health admission. VHA requires that each facility provide access to care at MH RRTPs through service agreements with other VA facilities or through referral to non-VA community residential care facilities.

The VA North Texas system includes a 40-bed DOM SUD at the Dallas VA Medical Center and a 69-bed DOM SUD at the Sam Rayburn Memorial Veterans Center in Bonham, Texas. The Central Texas VA system is in Temple, Texas, and has a 169-bed general domiciliary that offers substance use disorder treatment as a "track."

According to VHA's requirements, patients referred to MH RRTPs must be screened within seven business days by a team that includes a licensed mental health professional and a medical provider to determine whether admission is appropriate. If accepted, the patient must receive a tentative admission date and a point of contact at the MH RRTP.[4] So VHA can track admission wait times, the patient must be added to the pending bed placement list.[5] Since 2018, VHA has required staff to include information in the patient's electronic health record to improve tracking of program wait times and capacity.[6]

Community Care Program Eligibility Criteria

The MISSION Act mandated changes to VHA's community care program.[7] Those changes led to VHA's Office of Community Care issuing implementation guidance stating that "wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services." The guidance further said MH RRTPs "are considered institutional extended care services" and do not follow the same wait-time standards.[8] When MH RRTP care is not available within

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[4] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. Tentative admission date refers to the MH RRTP staff's expected date of bed availability.

[5] VHA Directive 1002, *Bed Management Solution for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

[6] VHA Deputy Under Secretary for Health for Operations and Management (10N) memo, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) CPRS Note Templates Implementation," July 30, 2018.

[7] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[8] VHA Office of Community Care, "Field Guidebook: Specialty Programs," updated November 3, 2021. The Office of Community Care determines a patient is eligible for community mental health care when the wait time is greater than 20 days or the drive time is greater than 30 minutes for a VHA outpatient mental health appointment.

VA facilities for an eligible patient who "elects to receive care in the community," VHA will authorize community residential care. Further, for MH RRTP admission wait times greater than 30 calendar days, facility staff must offer the patient alternative care that addresses the patient's needs and preferences, including a referral to community residential care or another VHA program. Additionally, facility staff should discuss outpatient care options with the patient while the patient awaits MH RRTP admission. It is important to note that the COVID-19 pandemic put additional stresses on VHA and that the Texas facilities were not alone in facing long wait times. In February 2021, VHA estimated that 3,500 patients nationally were pending admission with an average wait time of more than 150 days. At that time, VHA required MH RRTP staff to provide alternatives, including community residential care, if unable to admit patients within 30 days.[9]

The OIG Found VA North Texas DOM SUD Wait Times Exceeded Requirements and Staff Failed to Refer Patients to Community Residential Care as Required

The OIG team reviewed 15 VA North Texas DOM SUD consults to determine admission wait times and evaluate whether staff offered community residential care. The team substantiated the allegation that VA North Texas staff placed patients on waitlists for two to three months and failed to offer community residential care referrals during most of fiscal years 2020 and 2021, inconsistent with VHA requirements. It is important to note that the OIG did not identify any adverse clinical outcomes due to the patients' delayed access to residential care.

In March 2020, due to the pandemic, facility leaders restricted access to the Dallas DOM SUD to local veterans, in accordance with VHA guidance. The Dallas DOM SUD subsequently reopened to a broader group of patients but still with reduced capacity in September 2020. The Bonham DOM SUD remained open during the pandemic at reduced capacity until January 2022, when admissions were halted until June 2022 due to COVID-19 concerns. VHA data indicated that the Dallas and Bonham DOM SUDs' average wait times were 30 days or greater from the third quarter of fiscal year 2020 through the second quarter of fiscal year 2021, likely due to pandemic-related restrictions.

Of the 10 North Texas patients' records the OIG reviewed, five had one DOM SUD consult placed and the other five had two consults placed, resulting in a total of 15 consults examined. Of the 15 consults, 13 were referrals to the Bonham DOM SUD and two were referrals to the Dallas DOM SUD. Seven consults were closed when the patients were admitted within 30 days, declined screening, or were not approved for admission. Among the eight remaining consults, two were closed when the patients declined admission and six resulted in patients waiting an average of 79 days before VA North Texas staff offered DOM SUD admission or removed the patient from the pending bed placement list. For

[9] VHA Assistant Under Secretary for Health for Clinical Services memorandum, "Ensuring Access to Residential Treatment for Veterans with Mental Health and Substance Use Disorders during the Pandemic," February 11, 2021.

seven of the eight consults, staff documented that the "anticipated admission date exceeds 30 days; however, there is no available alternative to consider at this time."

The OIG determined that the VA North Texas chief for Patient Administration Services, who oversees community care, misinterpreted community care guidance and provided inaccurate information to VA North Texas leaders and staff. Specifically, the Office of Community Care's guidance states that community care wait time standards were not applicable to MH RRTP. Facility staff should have instead followed VHA policy requiring a patient with a wait time of greater than 30 days be offered alternative residential treatment or another level of care. Alternative residential treatment could include a referral to a community program, another program in the VISN, or another program in another VISN.[10]

However, the Patient Administration Services chief told the OIG team during the review that MH RRTPs are "excluded from the MISSION Act" and not eligible for community care based on access standards—reflecting an inaccurate understanding of the Act. In contrast, the national director of the MH RRTP reported that although drive time and wait time standards do not apply to DOM SUDs, community care referrals are expected when a patient is determined to require a residential level of care and VHA is unable to provide treatment within the required timeframe.

In September 2020, the MH RRTP national program office released guidance that included instructions for community care referrals. In February 2021, VHA provided guidance that VISN chief mental health officers and facility leaders must ensure that patients who require a residential level of care are offered a VA MH RRTP bed or community residential care. VHA further required that each facility provide the operational status of MH RRTP beds and "information on the availability of community based residential treatment options."[11] VISN 17's response to the February 2021 guidance indicated that the Dallas and Bonham DOM SUDs were not making community residential care referrals.

In December 2021, the OIG informed VISN 17 and VA North Texas leaders of staff's failure to comply with community residential care referral expectations and requested corrective action be taken to address staff education and potential patient treatment needs. VA North Texas leaders communicated referral requirements to Office of Community Care and Mental Health Services staff and reviewed all community residential care consults placed from October 1, 2019, through November 30, 2021. Additionally, in response to the OIG's request, VA North Texas staff completed a clinical review to ensure appropriate follow-up for patients referred from October 1, 2019, through December 31, 2021, to the Dallas and Bonham DOM SUDs whose wait times were greater than 30 days.

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[10] VHA Directive 1162.02.

[11] VHA assistant under Secretary for health for clinical services, "Ensuring Access to Residential Treatment for Veterans with Mental Health and Substance Use Disorders during the Pandemic," memorandum.

Recommendations for Corrective Action

In contrast to VA North Texas's failures, the OIG's review of two patients referred to the Temple DOM SUD by VA North Texas staff indicated the VA Central Texas staff placed consults and scheduled patients in accordance with VHA policy. Further, VA Central Texas developed procedures for community residential care referrals when MH RRTP wait times were greater than 30 days.

The OIG made five recommendations in this report related to VA North Texas deficiencies and associated lack of oversight.[12] The first recommendation was for the VA North Texas director to ensure that staff provide alternative treatment options, including community care when MH RRTP admission wait times exceed 30 days. VA concurred with this recommendation. The second recommendation called on the director to conduct a comprehensive review of the management of community residential care referrals. VA concurred in principle with this recommendation. VA concurred with the remaining three recommendations described below.

There Was Inadequate VISN Oversight

The OIG determined that VISN 17 leaders did not ensure local facilities were adhering to the national MH RRTP policy. According to the MH RRTP directive, each VISN mental health lead is responsible for ensuring that all MH RRTPs in their region collect data sufficient for oversight related to VHA policy implementation.[13] Additionally, the national director of the MH RRTP confirmed the VISN has oversight responsibility to ensure eligible patients have access to a residential level of care, although there are not defined expectations related to community care utilization monitoring. The VISN 17 chief mental health officer provided guidance to VA North Texas leaders on three occasions in 2021 regarding the use of community residential care. However, she reported that the VISN role did not carry the authority to ensure policy adherence or "direct oversight" because "oversight is at the local facility management level." The third report recommendation was for the under secretary for health to make certain that VISN leaders provide adequate oversight to ensure that access to care for MH RRTPs is provided consistent with VHA policy.

Bonham MH RRTP Nonadherence with VHA Scheduling Requirements

During the inspection, the OIG team also identified that the Bonham MH RRTP standard operating procedure was inconsistent with VHA's minimum scheduling effort requirements, as it instructed schedulers to close a consult after three failed scheduling contact attempts with patients rather than the four required. Since 2016, VHA has required healthcare providers to document a request for other

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[12] The OIG considers all five recommendations currently open pending the submission of sufficient documentation that would support that adequate progress has been made on implementing them. The OIG requests updates on the status of all open recommendations every 90 days, which are then reflected on the recommendation dashboard found on the OIG website. VA may, however, submit evidence of implementation sufficient to close a recommendation at any time. For this report, VA's first recommendation status update is due in mid-June.

[13] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

services in the referred patient's electronic health record. The second attempt must use a different method of contact and can be completed the same day as the first attempt, while the third and fourth attempts must be on different days. To allow the patient time to respond, providers' staff must wait a minimum of 14 calendar days from the second contact attempt before determining how to act on the consult request, such as closing the consult. Additionally, the Bonham MH RRTP staff were attempting to contact patients by phone and not using other modes of contact. Failure to adhere to VHA minimum scheduling requirements may hinder efficient patient scheduling and contribute to the barriers patients experience in accessing DOM SUD services. The fourth recommendation was for the VA North Texas director to ensure that Bonham MH RRTP scheduling procedures are consistent with VHA minimum scheduling effort requirements.

National Program Process Needed on Mental Health Treatment Coordinator Assignment

Finally, the OIG found that VA North Texas policy did not include information about the requirement for MH RRTP staff to assign a mental health treatment coordinator for patients awaiting admission to a residential program. Since 2012, VHA has required facility staff to assign a mental health treatment coordinator to patients who are receiving treatment in an outpatient mental health setting, have been admitted to an inpatient mental health setting, or are "waiting to engage in a different level of care," including an MH RRTP bed.[14] However, in an interview, the national director for the MH RRTP acknowledged not having an assignment process for patients waiting for MH RRTP admission. This failure to develop a national-level process likely contributed to the VA North Texas MH RRTP leaders' lack of knowledge that the VA North Texas policy should address the identification and assignment of a mental health treatment coordinator for accepted patients awaiting admission. Not only can this lack of policy awareness contribute to a coordinator not being assigned, it can also diminish the likelihood of patients' engagement in outpatient care while waiting for placement. The fifth report recommendation is related to strengthening coordinator assignment procedures for patients waiting for an MH RRTP bed.

MISMANAGEMENT OF A PATIENT WITH ALCOHOL WITHDRAWAL AT THE TOMAH VA MEDICAL CENTER

In 2021, the OIG issued a report reviewing allegations related to the care at the Tomah VA Medical Center of a patient suffering from alcohol withdrawal who subsequently died at another VA medical center from a presumed anoxic (lack of oxygen) brain injury.[15] The inspection team found that facility physicians' failure to prescribe an adequate medication regimen to address the patient's delirium tremens (withdrawal symptoms) effectively, review the patient's abnormal electrocardiogram prior to haloperidol administration, and transfer the patient earlier likely contributed to the patient's deterioration

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[14] VHA Deputy Under Secretary for Health for Operations and Management memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[15] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, August 21, 2021

and ultimate death. The team substantiated that a non-VA paramedic documented that a supplemental oxygen flow was not active.[16] Tomah VA Medical Center leaders and staff reported they did not know about the failed oxygen delivery. The inspection team also found that the nursing staff did not complete all required alcohol withdrawal assessments; a physician improperly ordered restraints; nurses failed to obtain full vital signs while the patient was in restraints; and nurses did not receive restraint training as expected. Finally, leaders did not conduct an institutional disclosure with the patient's family in a timely manner, as required.

The OIG made 10 recommendations to the facility director related to educating personnel on alcohol withdrawal and cardiac risks, the need for a review to determine the causes of the failed oxygen delivery, identification of root causes and performance deficiencies, workgroup outcomes, alcohol withdrawal assessment protocol adherence, restraint management and training, compliance with admission criteria, emergency detention, and institutional disclosures. The Tomah VA Medical Center has provided documentation on sufficient corrective actions and the recommendations are closed.

Assessing and stabilizing patients who are at risk for life-threatening complications from alcohol withdrawal is critical. Failure to ensure appropriate staff training on such care puts patients at risk for severe consequences, including death. Because hospitals in rural settings often have limited specialty and intensive care services on-site that do not meet the need for higher-level care, clinical interventions related to assessment and stabilization are even more critical while patient transfer arrangements are made.

OTHER OIG REPORTS CITING CONCERNS WITH COMMUNITY CARE COORDINATION OF VETERANS WITH COMPLEX MENTAL HEALTH NEEDS

Coordinating medical care between VHA and community providers remains a challenge, particularly for addressing the needs of patients with complex mental health conditions. The OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between care providers and their patients. These deficiencies challenge the considerable efforts of VHA personnel to ensure a seamless experience for veterans. Many OIG reports have described the frustrations and, most importantly, the risks to patients associated with referrals to the community when coordination and communication are inadequate. The following reports exemplify how poor care coordination contributes to sometimes tragic consequences for high-risk patients.

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[16] Tomah VAMC Policy MS-03, *Emergency Services*, March 7, 2017, requires staff to respond to medical emergencies by calling "911," as necessary for non-VHA emergency assistance. The emergency medical services personnel who responded to the patient included a lead paramedic, a second paramedic, and an emergency medical technician. The paramedics performed an endotracheal intubation on the patient and the patient was transported to a non-VHA facility by helicopter. The lead paramedic completed the documentation that noted failed oxygen delivery. Three days later, the patient was transferred from the non-VHA hospital to another VA medical center.

In a report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the OIG review team found that administrative errors and confusion in the Phoenix VA healthcare facility's community referral process delayed specialized psychological testing for a veteran. The veteran died by suicide never having received the appropriate testing and resulting targeted treatment.[17]

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care between the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.[18] In addition, the patient suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community.

AN ONGOING FOCUS ON RURAL VETERANS, COMMUNITY CARE COORDINATION, AND MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Considering VA's persistent challenges caring for high-risk and complex patients identified in prior reviews, the OIG continues to initiate proactive projects to highlight threats to patient safety and quality of care as well as detail specific facilities' innovative solutions to these issues. The following work demonstrates the OIG's broad oversight footprint across VA and our continued focus on veterans who require mental health and substance use disorder treatment, with special consideration for those living in rural locations.

In the past two fiscal years, OIG's healthcare inspection teams conducting cyclical reviews visited nine medical centers designated by VA as rural.[19] OIG teams also performed inspections of 12 VISNs that are responsible for the management of 265 rural and highly rural facilities and community based outpatient clinics. During FY 2024, the OIG will be rolling out an updated healthcare facility inspection program that will use a more customized and data-driven approach to better highlight distinct challenges that affect the quality of healthcare delivery, such as those specific to rural settings.

The OIG's cyclical reviews of vet centers have focused on 36 locations, with three in rural and highly rural settings. Vet centers are community-based counseling centers that offer myriad services to eligible veterans, service members, and their families.[20] These centers are critical to VHA's efforts to expand outreach and support more veterans in getting the care they need, particularly mental health care.

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[17] VA OIG, *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona*, March 31, 2021.

[18] VA OIG, *Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee*, September 3, 2020.

[19] VHA has a total of 16 medical centers, hospitals, or healthcare systems in rural locations.

[20] For more information, visit the vet center website at www.vetcenter.va.gov/.

Moreover, VA's 80 mobile vet centers are meant to be used for outreach and services to underserved populations—often in highly rural areas. The OIG's vet center review teams are including mobile vet centers in their current inspection cycle.

The OIG's newest planned cyclical review will inspect mental health inpatient units of all sizes across the system. Currently in the pilot phase, the planned launch is for FY 2024. In July 2023, a new VISN community care cyclical review is also being undertaken to evaluate the administrative and care coordination processes to veterans receiving care through VHA's Community Care Network (CCN).

A review will also soon be released that assessed care coordination for patients of the VA Eastern Kansas Health Care System who have been receiving care and dually prescribed opioids and benzodiazepines from CCN providers.[21] Veterans are at a higher risk of harm associated with concurrent use of opioid and benzodiazepine medication due to the prevalence and severity of chronic pain that is often accompanied by mental health comorbidities when compared to nonveterans. The OIG team assessed VHA and CCN providers' care coordination, documentation processes, and use of risk-mitigation strategies for patients, as well as VHA's oversight of CCN providers' opioid prescribing practices.

After Congress passed the SUPPORT for Patients and Communities Act in 2018, requiring the expansion of substance use disorder treatment, the Office of Mental Health and Suicide Prevention developed a large-scale national hiring initiative to expand the availability of such treatment to veterans at VA medical centers during FY 2022. This initiative included a requirement to hire 90 percent of the 1,180 approved positions before the end of September 2022. The OIG is currently assessing how well medical centers have met the FY 2022 substance use disorder hiring initiative goal. The review team has already analyzed national hiring data at 139 medical centers to determine if the facilities achieved the initiative goal. The team selected a statistical sample of four medical centers (two of which are located in rural areas) for a deeper review to understand how different VISNs and medical centers managed the initiative and to identify any internal obstacles to facilities' meeting the hiring goal.

Collectively, these OIG reviews and other oversight reports provide veterans and their families, VA staff and leaders, the public, and Congress with a comprehensive understanding of VA health care and mental health services delivered in a variety of settings.

CONCLUSION

Every veteran deserves high-quality, timely, and well-coordinated care. This is particularly critical for veterans in rural areas with limited resources who are at high risk due to their mental health and substance use conditions. The pandemic disrupted healthcare delivery in all practice areas, including addiction treatment, while escalating the demand for interventions. VHA will need to continue to rely on

[21] VHA has been sent a copy of the report and it is under review for their comments.

community providers to deliver care when veterans’ needs cannot be met within VA’s own facilities. As the reports highlighted in this testimony demonstrate, VHA faces numerous challenges in providing needed substance use and mental health treatments—exacerbated by the limited availability of appropriate treatment services for veterans living in rural and highly rural locations. The OIG will continue to focus on these matters to assist VA in mitigating the risks inherent in providing and coordinating behavioral health care both within VHA and with community partners.

Chairman Tester, Ranking Member Moran, and members of the committee, this concludes my statement. I would be happy to answer any questions you may have.