



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Staffing and Quality of Care Issues VA Black Hills Health Care System Hot Springs, South Dakota

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Executive Summary

At the request of Senators Tim Johnson and John Thune, and Representative Kristi Noem, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations regarding staffing and quality of care and safety concerns at the VA Black Hills Health Care System, Hot Springs, SD.

On May 8, 2012, the Senators and Representative forwarded to the OIG a letter from complainants requesting an onsite review to assess the current hiring, staffing, and managerial support for clinical care at the Hot Springs division of the VA Black Hills Health Care System.

Specifically, the complainants alleged that *only* temporary staff were hired for critical clinical positions and that staffing issues led to quality of care and safety concerns.

During our onsite interviews, we received numerous complaints regarding a “proposal of change”¹ for the Hot Springs division. We did not address these complaints as they were outside the scope of this review.

We received two additional allegations while onsite:

- 1E combined medical/community living center unit had understaffing and mandatory overtime issues.
- Hot Springs Pharmacy was understaffed with an increased workload.

We did not substantiate that:

- *Only* temporary staff were hired for critical clinical positions.
- Hiring temporary staff led to quality of care or safety issues.
- 1E was understaffed or that staff worked excessive amounts of mandatory overtime.

We did not review pharmacy staffing due to unavailability of individual workload data.

We recommended that the VA Black Hills Health Care System Director reevaluate Hot Springs division 1E staffing and overtime based on VHA Nurse Staffing Methodology and obtain a VA Pharmacy external review of the pharmacy workload and staffing needs.

The Veterans Integrated Service Network Director and the VA Black Hills Health Care System Director agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.

¹ VHA document detailing a proposed change to the future mission of the Hot Springs division.



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

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

SUBJECT: Healthcare Inspection – Alleged Staffing and Quality of Care Issues,
VA Black Hills Health Care System, Hot Springs, South Dakota

Purpose

At the request of Senators Tim Johnson and John Thune, and Representative Kristi Noem, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding staffing and quality of care and safety concerns at the Hot Springs division of the VA Black Hills Health Care System (the system) located in Hot Springs, SD.

On May 8, 2012, the Senators and Representative forwarded OIG a letter from complainants requesting an OIG onsite review to assess the current hiring, staffing, and managerial support for clinical care at the Hot Springs division of the VA Black Hills Health Care System.

Specifically, the complainants alleged that:

- *Only* temporary staff were hired for critical clinical positions.
- Staffing issues led to quality of care and safety concerns.

Background

The system consists of two divisions located in Fort Meade and Hot Springs, SD. It is part of Veterans Integrated Services Network (VISN) 23, has 12 community based outpatient clinics, and serves approximately 30,000 veterans in South Dakota and portions of Nebraska, North Dakota, Wyoming, and Montana.

The Hot Springs division provides inpatient acute, community living center (CLC), outpatient, mental health transitional and residential care, as well as domiciliary residential rehabilitation. Total full-time employee equivalents (FTE) for the Hot Springs division is approximately 360.

On December 12, 2011, VISN 23 and system leaders presented a proposal of change² for the Hot Springs division. This has led to tension with some Hot Springs staff and community members. To accommodate all stakeholders, VA Secretary Eric Shinseki extended the proposal comment period through June 30, 2012. VISN 23 and system leaders were to submit a final reconfiguration recommendation by the end of July.³ VISN and system leaders were subsequently granted an extension and are now expected to submit their final recommendation by early September.

Scope and Methodology

To address the allegations, we conducted onsite reviews June 4–8, 2012. We interviewed the complainants, system leadership, service chiefs, quality management staff, a union representative, and other clinical staff who requested to meet with us. We reviewed quality management documents, vacancy and recruitment announcements, hiring data, patient electronic health records, medical center policies, VHA Directives, patient advocate data, and staffing methodology and data. We completed some of the work via secure data exchange, e-mail, and telephone.

During our onsite interviews, we received two additional allegations regarding staffing on specific Hot Springs units. The first allegation was that nursing staff on the 1E combined medical/CLC unit were understaffed, were working excessive mandatory overtime leading to exhaustion, and were fearful of making clinical mistakes with patients because of this exhaustion. The second allegation was that the Pharmacy was understaffed for an increasing workload.

We did not address allegations regarding the proposal for change as they were outside the scope of this review.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Temporary Staffing

We did not substantiate the allegation that the Hot Springs division hired *only* temporary staff for critical clinical positions.⁴

The Office of Personnel Management (OPM) defines temporary employment as an appointment lasting 1 year or less with a specific expiration date.⁵ This timeframe may

² VHA document detailing a proposed change to the future mission of the Hot Springs division.

³ Letter from VA Secretary Eric K. Shinseki to Senator Tim Johnson dated May 18, 2012.

⁴ For the purpose of this review, we consider critical clinical positions to be nurses, physicians, and pharmacists.

be extended to meet an employment need such as reorganization, abolishment, or other unusual circumstance. A temporary employee's appointment may be terminated at any time.⁶ The employee is not eligible for promotion, reassignment, or transfer to other jobs.

Contract employees are used to fill a position that the system is unable to fill by other means (such as regular recruitment). Contracts are bid and filled for a specified time for a specific service or function. A locum tenens is a non-VHA medical provider that serves for a specified period of time in the place of another provider such as a hospitalist or a specialty care provider.

We reviewed recruitment and hiring data for nurses, physicians, and pharmacists. Actual staffing data is in Tables 1–3. The percentage of 1E temporary nursing staff was 9.2 percent.⁷ Since the arrival of the new Chief of Staff in December 2011, the practice has been to hire permanent, contract, or locum tenens physicians. Pharmacists were hired as either permanent employees or on a contract basis.

The Executive Council is reviewing vacancies and making staffing decisions based on workload and management data while balancing the possible outcomes of the pending changes to the division's mission. We did not find local policies or VHA Directives requiring facilities to fill clinical staff positions with only permanent hires.

Nurse Staffing

As shown in Table 1 on the next page, the Hot Springs division 1E was allocated 14.2 registered nurses (RNs), 4 licensed practical nurses (LPNs), and 3 nursing assistants (NAs).⁸ Actual FTE staff on duty are 15.7 RNs, 4 LPNs, and 2 NAs. On duty RNs exceed allocated RNs by 1.5 FTE. One NA position is currently in recruitment. As of July 10, 2012, there are two positions filled with temporary nursing staff, an RN and LPN. Over 90 percent of the 1E nursing staff are permanent.

⁵ Government Printing Office website, <http://www.gpo.gov/fdsys/pkg/CFR-2012-title5-vol1/pdf/CFR-2012-title5-vol1-sec213-104.pdf>, accessed July 19, 2012.

⁶ VA Black Hills Health Care System definitions of Temporary, Contract, and Locum Tenens provided by Human Resources, email dated July 18, 2012.

⁷ Note: the percentage of temporary employees out of *all* 1E nursing staff FTE was calculated using $(2 \text{ temp} / 21.7 \text{ all employees}) * 100 \text{ percent} = 9.2 \text{ percent}$.

⁸ Nurse staffing allocations are calculated using the VHA Nurse Staffing Methodology.

Table 1. Hot Springs Division 1E Medical/CLC Unit Staffing.

| Allocated Staff | Actual Staffing | Type of Staff |
|---|---|--|
| 14.2 RNs | 13 RN on duty | Permanent |
| | 1 RN on duty | Temporary |
| | 0.2 RN on duty | Intermittent |
| | 1.5 RN on duty | Detailed from Operating Room |
| | 15.7 TOTAL RNs ON DUTY | |
| 4 LPNs | 3 LPNs on duty | Permanent |
| | 1 LPN on duty | Temporary |
| | 4 TOTAL LPNs ON DUTY | |
| 3 NAs | 2 NAs on duty | Permanent |
| | 1 NA in recruitment | Permanent - in recruitment status |
| | 2 TOTAL NAs ON DUTY | |
| 21.2 Total Nursing Staff Allocated | 21.7 Total Nursing Staff on Duty | 0.5 Nursing Staff Over Allocation |

Physician Staffing

As shown in Table 2 below, the Hot Springs division was allocated 12.4 FTE physicians and has 11.05 FTE physicians on duty. Physician staffing is below allocation levels for 1 FTE hospitalist and 0.35 FTE general surgeon. There are no temporary physicians on duty for Hot Springs. The physicians are either permanent, locum tenens, or under contract. Recruitment is ongoing for vacant physician positions.

Table 2. Hot Springs Division Physician Staffing.

| Allocated Staff | Actual Staffing | Type of Staff |
|--|---|--|
| 5 Hospitalists | 1 Hospitalist | Full Time (FT) - Permanent |
| | 3 Hospitalists | Locum Tenens - Ongoing recruitment for 4 FTE |
| | 1 Hospitalist Vacant Position | Advertised for Locum Tenens or FT Staff |
| | 4 Hospitalists on Duty | |
| 1 Urgent Care Physician | 1 Urgent Care Physician on Duty | Locum Tenens |
| 2 Primary Care Clinic Physicians | 2 Primary Care Physicians on Duty | FT – Permanent |
| 1 Compensation and Pension Medical Director | 1 Compensation and Pension Physician on Duty | FT Permanent |
| 2 Psychiatrists | 2 Psychiatrists on Duty | FT Permanent |
| 0.2 Ophthalmologist | 0.2 Ophthalmologist on duty | Contract |
| 0.2 Nephrologist | 0.2 Nephrologist on Duty | Contract |
| 0.5 General Surgeon | 0.1 General Surgeon | FT Permanent - at Hot Springs 2–3 days/month |
| | 0.05 General Surgeon | Part Time Permanent - 1 day/month |
| | 0.15 General Surgeon on Duty | Ongoing Recruitment for 0.5 FTE |
| 0.5 Urologist | 0.4 General Urologist | Contract |

| | | |
|---|--|---|
| | 0.1 General Urologist | Contract |
| | 0.5 General Urologist on Duty | Coverage provided 10 days/month |
| 12.4 Total Physician Staff Allocated | 11.05 Total Physician Staff on Duty | 1.35 Total Physician Staff Allocated Not on Duty |

Pharmacy Staffing

As shown in Table 3 below, the Hot Springs division Pharmacy was allocated 10.8 FTE pharmacists (includes the Associate Chief of Pharmacy) and 7 pharmacy technicians. Actual on duty pharmacy staffing consists of 8.8 FTE pharmacists and 7 technicians. Two of the technicians work in the Hot Springs Call Center (under the supervision of the Associate Chief of Pharmacy) with five technicians filling prescriptions in the Pharmacy. Of the 2 remaining FTE, 1 pharmacist FTE’s contract is in progress and another position is in recruitment. All pharmacy positions are either permanent or under contract.

Table 3. Hot Springs Division Pharmacy Staffing.

| Allocated Staff | Actual Staffing | Type of Staff |
|--|--|---|
| 1 Associate Chief | 1 Associate Chief of Pharmacy on duty | Permanent |
| 9.8 Pharmacists | 6.8 - all Clinical Pharmacy Specialists on duty | Permanent |
| | 1 Pharmacist on duty | Contract |
| | 1 Pharmacist in contract progress | Contract arriving end of June 2012 |
| | 1 Pharmacist in recruitment | Permanent –Mental Health funding initiative |
| | 8.8 Pharmacists TOTAL ON DUTY (includes Associate Chief Pharmacist) | |
| 7 Technicians | 5 Technicians on duty | Permanent |
| | 2 Technicians on duty at the Call Center | Permanent |
| | 7 Pharmacy Technicians TOTAL ON DUTY | |
| 17.8 Total Pharmacy Staff Allocated | 15.8 Total Pharmacy Staff on Duty | 2 Total Pharmacy Staff Allocated Not on Duty |

Issue 2: Quality of Care and Safety

We did not substantiate that the Hot Springs division has current quality of care or safety issues.

In interviews with the complainants and other Hot Springs clinical staff, interviewees told us that the veterans were receiving excellent care. No one provided specific quality of care or safety cases for us to review. Nursing staff related that they were very concerned that something was going to “slip through the cracks” because of insufficient or temporary staffing, exhaustion due to excessive mandatory overtime, or the proposed mission changes. Clinicians told us that a few veterans were transported to other facilities and inconvenienced (1½–3-hour trip times) because some specialty services were restricted or no longer provided at the Hot Springs division. However, there were

no cases of poor quality of care resulting from the transportation to other VA facilities for specialty services unavailable at Hot Springs.

We interviewed the Chief of Quality Management and reviewed quality management data.⁹ We reviewed FY10 through FY12 incident reports, peer reviews, Root Cause Analyses, tort claims, medical record quality review results, VHA Inpatient Evaluation Center (IPEC) reports,¹⁰ National Utilization Management Integration (NUMI) data,¹¹ and Survey of Health Experience of Patients (SHEP) scores.¹² We did not find evidence of poor quality of care, safety issues, or concerning trends at the Hot Springs division.

Issue 3: Other Issues

Nurse Staffing – 1E

During interviews with nursing staff, we were told that 1E was understaffed and they were required to work excessive amounts of mandatory overtime.

1E is a combined general medical and CLC unit with 10 authorized medical beds and 7 authorized CLC beds. The 1E daily average patient census is 10.2. Total 1E nursing staff FTE is 21.7. The facility used the VHA Staffing Methodology¹³ to develop staffing levels.

VHA's Nursing Office implemented a Staffing Methodology Directive. VHA facilities are required to apply a nationally standardized methodology process to determine staffing for VA nursing personnel for all inpatient points of care. Each inpatient unit develops targets for their Nurses Hours per Patient Day (NHPPD) and daily average patient census. They are required to calculate and track the actual NHPPD and actual patient census. If actual numbers do not meet target values, the targets should be recalculated or staffing levels adjusted. Facilities need to do target comparisons using other VA facilities with similar sizes and types of units. Facilities successfully following the VHA Nurse Staffing Methodology should have adequate staffing to meet patient care and safety needs on each inpatient unit.

Using the Staffing Methodology with the NHPPD and staffing data developed by the 1E Nurse Manager and Associate Director for Patient Care Services, we reviewed the actual NHPPD for 30 randomly selected days between October 2011 and March 2012. The days selected included weekdays, weekends, and holidays. Figures 1–4 (located in Appendix A) are the results of the OIG Staffing Methodology variance analysis for 1E.

⁹ Quality management is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

¹⁰ IPEC LINKs SharePoint site, vaww1.va.gov/ipecc, accessed June 7, 2012.

¹¹ VHA DIRECTIVE 2010-021, *Utilization Management Program*, May 14, 2010

¹² VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly and employees are surveyed annually.

¹³ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

The dark continuous line on each graph indicates the 1E target values for NHPPD and average daily census. Overall, we found that the actual staffing levels on 1E exceeded the targeted staffing level (see Figure 4).

Nursing Staff Overtime

During onsite interviews, we received several complaints that nursing staff were extremely tired and worried they would make patient care mistakes from working excessive mandatory overtime. Mandatory overtime is guided by a union contract that specifies that nursing staff with less seniority are mandated to work overtime before staff with more seniority. Voluntary overtime is requested by nursing staff and authorized through the Nurse Manager.

We reviewed 1E mandatory and voluntary overtime. For 21 nursing staff, there were 103 hours of mandatory overtime worked in Q3 and Q4 FY11¹⁴ and 48 hours of mandatory overtime worked in FY12 through June 6, 2012 (Q1 to Q3). Using Table 4 data, the majority of overtime worked in FY12 was voluntary (approximately 1300 hours).¹⁵ In FY12, nursing staff worked 212.25 additional total overtime hours compared to the same time period in FY11 (Table 4). Because the majority of overtime worked is voluntary overtime, we do not find that mandatory overtime is a large factor in 1E nursing staff fatigue. Nurse managers and system leadership should closely monitor scheduling based on workload, which should limit overtime needed.

Table 4. Hot Springs Division 1E Medical/CLC Unit Nursing Staff Total Overtime

| Oct-Mar FY11 | | Oct-Mar FY12 | |
|-----------------|----------------|-----------------|----------------|
| Overtime Amount | Overtime Hours | Overtime Amount | Overtime Hours |
| \$49,008.40 | 1,201.00 | \$55,751.02 | 1,412.25 |

Pharmacy Staffing

We received onsite complaints regarding the Hot Springs pharmacy staffing. Complainants felt that the pharmacy was understaffed and overworked because of a large and increasing workload. We requested but did not receive pharmacy workload data. Without this data, we were unable to evaluate the staffing needs or actual workload for each member of the pharmacy staff. We discussed this issue with system leadership who agreed that an external VA pharmacy review would help evaluate pharmacy staffing and workload levels.

¹⁴ Nurse Manager did not track mandatory overtime until Q3 FY11.

¹⁵ Total overtime given in Table 4 is for Q1-Q2 FY11 and FY12. Approximate values are given for voluntary overtime because mandatory overtime was spread out over three quarters, Q1-Q3.

Conclusions

We did not substantiate that a decision was made to *only* hire temporary staff for critical clinical positions. Both permanent and temporary staff were hired for open positions with the majority of positions filled by permanent hires. We did not substantiate that there are current quality management or safety issues at the Hot Springs division. After interviewing clinical staff and leadership and reviewing quality management data, we found that there were no quality or safety incidents that could be linked to temporary staff positions.

We did not substantiate that 1E was understaffed or that staff worked excessive mandatory overtime. We analyzed 1E staffing data and found that overall the NHPPD were significantly above the unit's target staffing levels. We also noted that most of the overtime worked was voluntary.

We were unable to review pharmacy staffing due to unavailability of individual workload data. Pharmacy workload and staffing requires further evaluation by an external VA Pharmacy consultant.

Recommendations

Recommendation 1. We recommended that the Director reevaluate 1E staffing based on VHA Nurse Staffing Methodology and closely monitor overtime.

Recommendation 2. We recommended that the Director obtain a VA Pharmacy external review of the pharmacy workload and staffing needs.

Comments

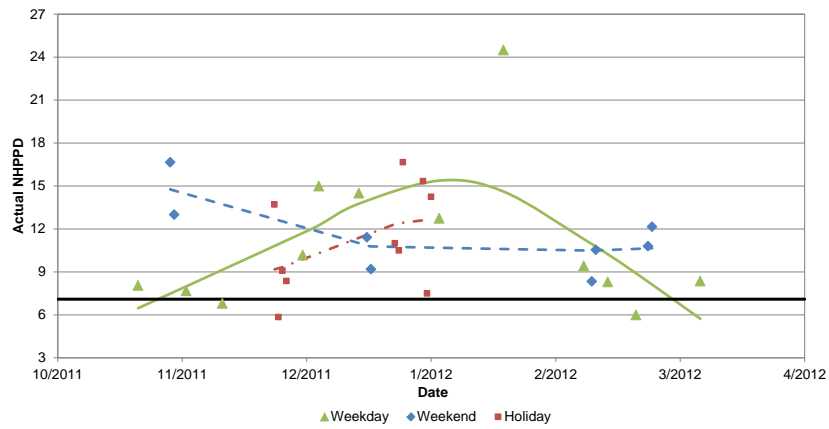
The VISN and facility Directors agreed with the findings and recommendations (see Appendixes B and C, pages 11–14, for the full text of their comments). The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.



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

Figures 1–4 are the OIG Variance Analysis Results for 1E Nurse Staffing.

**Figure 1. Sampled Actual NHPPD for the 1E Medical/CLC Unit
October 1, 2011–March 31, 2012**



**Figure 2. Patients (Census) for the 1E Medical/CLC Unit
October 1, 2011–March 31, 2012**

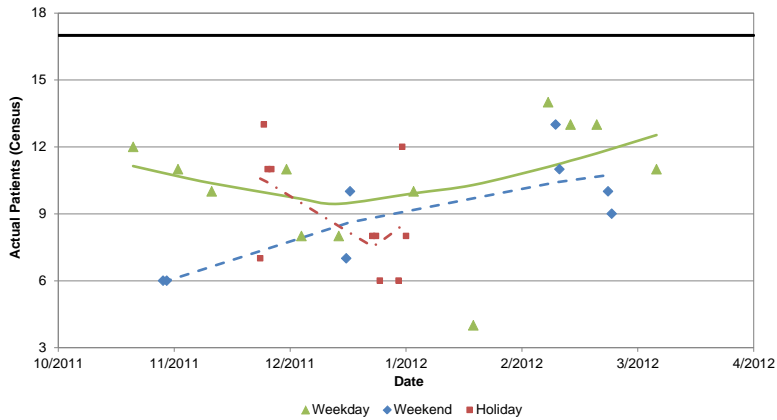


Figure 3. Sampled Actual NHPPD and Patients (Census) for the 1E Medical/CLC Unit October 1, 2011–March 31, 2012

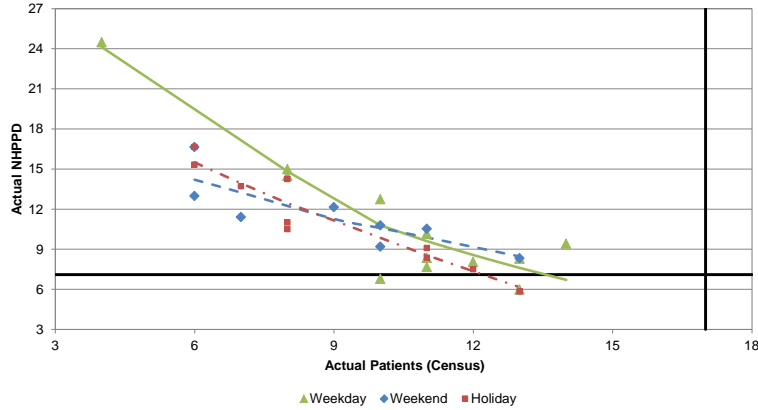


Figure 4. Estimated NHPPD and Daily Patients for the 1E Medical/CLC Unit October 1, 2011–March 31, 2012

| NHPPD | | | | Patients (Census) | | | |
|----------------|-----------|------------------------------|--|-------------------|-----------------------------|-------------------------|---|
| Sample Size | Mean | 95% Confidence Interval | Estimate is Statistically Significantly Different from the Target (7.10) | Sample Size | Mean | 95% Confidence Interval | Estimate is Statistically Significantly Different from the Target (17.00) |
| Holiday | 10 | 11.22 | * | 10 | 9.00 | * | |
| Weekday | 11 | 10.96 (7.842, 14.083) | Above | 11 | 10.42 (8.757, 12.076) | | Below |
| Weekend | 8 | 11.52 (8.083, 14.947) | Above | 8 | 9.00 (5.393, 12.607) | | Below |
| Overall | 29 | 11.12 (9.015, 13.223) | Above | 29 | 9.98 (8.742, 11.209) | | Below |

* All holiday-related data are reviewed.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 13, 2012

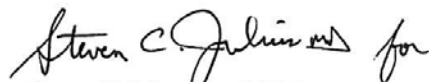
From: Director, VA Midwest Health Care Network (10N23)

Subject: **Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, VHA Management Review Service (10AR)

1. Attached please find our response to the Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota June 4–8, 2012.
2. If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 720-7311.



Janet P. Murphy, MBA

Director, VA Midwest Health Care Network (10N23)

Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 13, 2012

From: Director, VA Black Hills HCS (568)

Subject: **Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota**

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

1. Attached please find our response to the Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota June 4–8, 2012.
2. If you have any questions, you may contact me at (605) 720-7311.



Stephen R. DiStasio, FACHE
Director, VA Black Hills Health Care System (568)

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

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

OIG Recommendations

Recommendation 1. We recommended that the Director reevaluate 1E staffing based on VHA Nurse Staffing Methodology and closely monitor overtime.

Concur

Facility's Response:

The 1E Staffing Methodology Committee is reevaluating the targeted nursing hours per patient day. Upon completion, they will present their recommendations to the Facility Staffing Methodology Committee, the Associate Director, Patient Care Services/Nurse Executive and the Director for final approval.

Target Completion Date: September 30, 2012

The Associate Director, Patient Care Services/Nurse Executive continues to work closely with the 1E Nurse Manager to identify new nursing delivery models and staffing plans to decrease the amount of overtime. The Nurse Manager closely monitors overtime on a daily basis and reports same to Deputy Nurse Executive.

Target Completion Date: Ongoing Process

Status: In process

Recommendation 2. We recommended that the Director obtain a VA Pharmacy external review of the pharmacy workload and staffing needs.

Concur

Facility's Response: An initial external review of the pharmacy workload and staffing needs is currently planned to occur with the VISN 23 Pharmacy Coordinator via conference call.

Target Completion Date: August 30, 2012

An onsite extensive review of pharmacy programs, configuration, workload and staffing needs with a VISN and National Pharmacy Consultant is scheduled to occur in October.

Target Completion Date: October 31, 2012

Status: In process

OIG Contact and Staff Acknowledgments

| | |
|-----------------|---|
| OIG Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| Acknowledgments | Robert Yang, MD, Project Leader Laura Dulcie, BSEE, Team Leader Virginia Solana, RN, MA Limin Clegg, Ph.D. Nathan McClafferty, MS Patrick Smith, MS Jarvis Yu, MS |

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