Administrative Closure
Alleged Quality of Care Issues
St. Cloud VA Health Care System (656/00)
St. Cloud, Minnesota
MCI # 2012-00336-H1-0300

The VA Office of Inspector General Office of Healthcare Inspections received allegations from a mental health (MH) provider (the complainant) regarding psychiatric care in the Residential Rehabilitation Treatment Program (RRTP) at the St. Cloud VA Health Care System, St. Cloud, MN.

The complainant alleged that she was discouraged from providing individual counseling for veterans with post-traumatic stress disorder (PTSD) and military sexual trauma (MST). She also alleged that a supervisor prohibited her from including references to trauma or symptoms attributed to trauma from psychological evaluations for patients admitted to the RRTP because those references would be used to support claims for service-connected compensation benefits.

The complainant also alleged that an addictions therapist at the RRTP was receiving psychiatric treatment and that the Chief of the Domiciliary referred to PTSD as "the fleecing of America." These additional allegations were outside the scope of our review.

We contacted the complainant during the week of Oct 19, 2011, to schedule an interview. The complainant told us that she wanted to first speak with her attorney due to an ongoing Equal Employment Opportunity complaint related to her recent termination. We subsequently sent e-mail messages to the complainant attempting to schedule an interview. The complainant indicated a desire to proceed but did not respond to our requests for a specific date and time for a telephone interview. On December 1, 2011, we sent our last correspondence to the complainant's personal e-mail address. In this message, we again requested possible interview dates and times. As of January 13, 2012, the complainant had not responded.

We evaluated the information we received in the Hotline complaint. The complaint did not provide sufficient patient information for evaluation of the allegation pertaining to individual counseling. However, we were able to identify two patients from the complaint. We reviewed medical records for these patients and found that references to trauma, symptoms related to trauma, MST, and PTSD had been entered by MH providers, including the supervising clinician. Our review of these medical records did not support the allegation that use of the trauma-related terms was prohibited.

Based on our review of two electronic medical records and the complainant's failure to respond to repeated requests to schedule a telephone interview, we recommend administrative closure.

April 10, 2012
OHI staff: (b)(6)

Approved by: John D. Daigh, JR., M.D.
John D. Daigh, JR., M.D.
Assistant Inspector General
for Healthcare Inspections
4/11/12