US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Individual Psychotherapy at the Northport VA Medical Center in New York

Healthcare Inspection | 26-01069-255 | August 26, 2026

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on February 9, 2026, to review an allegation that facility leaders instructed psychotherapists to limit individual psychotherapy to 24 sessions and that two patients had their psychotherapy terminated as a result. The inspection team conducted virtual interviews from February 12 through April 9, 2026.

The OIG did not substantiate that Northport VA Medical Center (facility) leaders instructed psychotherapists to limit individual psychotherapy to 24 sessions. Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," established a recommended typical psychotherapy episode of care of "up to 24 weekly sessions," and allowed psychotherapists to provide extended care when clinically indicated.[1] However, the OIG determined facility leaders linked the volume of extended care caseloads (patients treated beyond 24 sessions) to Focused Professional Practice Evaluations (FPPEs) for Cause.

Key Findings

Individual Psychotherapy Sessions

The OIG found that individual psychotherapy was not limited to 24 sessions, and the facility standard operating procedure allowed extensions based on clinical need. The facility standard operating procedure also offered peer consultation as a resource "to allow for interdisciplinary input" when extended care was considered. While many psychotherapists reported feeling supported in extending care beyond 24 sessions, consulting with peers created inconsistent experiences and, for some, contributed to hesitancy seeking input through the peer consultation process.

Extended-Care Caseload Benchmarks in FPPEs

Facility Standard Operating Procedure 116A-016 states that a psychotherapist's extended-care caseload should be maintained below 25 percent.[2] Beginning in March 2025, facility leaders linked psychotherapists' extended-care caseloads to FPPEs for Cause, which may influence providers to factor caseload expectations into clinical decisions. Some psychotherapists told the OIG they made difficult decisions about terminating patients who they believed could still benefit from psychotherapy and felt pressured to do so against clinical judgment.

[1] Facility Policy 116A-016, "Individual Psychotherapy Standard Episode of Care," March 1, 2025. The policy was updated in November 2025 and kept the same expectations as the March 2025 policy as it relates to typical episode-of-care length.

[2] Facility Policy 116A-016.

Impact on Veterans

The OIG reviewed patients' electronic health records referenced in the original allegation as well as additional patients identified during the inspection and did not identify adverse clinical outcomes (hospitalizations, overdoses, suicidal behavior, or death). The OIG found that these patients were engaged in mental health care or had declined further care. However, linking extended-care caseload expectations to FPPEs for Cause benchmarks may influence psychotherapists to make treatment-length decisions based on the benchmarks rather than clinical judgment.

Recommendations and Next Steps

The OIG made two recommendations to the Facility Director to evaluate the inclusion of psychotherapy extended-care caseload metrics into performance measures and to assess whether any patients discharged during a provider's FPPE for Cause experienced harm. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and planned to implement a standardized process to review psychotherapy extended-care caseload metrics and ensure a review of cases where psychotherapy is terminated during a provider's FPPE for Cause (see appendixes A and B).[3] The OIG will follow up on the planned actions until compliance is achieved.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

3 VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated August 14, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Contents

Executive Summary i

Abbreviations iv

Introduction 1

Scope and Methodology 2

Inspection Results 3

Individual Psychotherapy Sessions 3

Extended-Care Caseload Benchmarks in FPPEs 5

Conclusion 6

Recommendations 1–2 7

Appendix A: VISN Director Memorandum 8

Appendix B: Facility Director Memorandum 9

OIG Contact and Staff Acknowledgments 12

Report Distribution 13

Abbreviations

FPPE	focused professional practice evaluation
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on February 9, 2026, to review an allegation that leaders at the Northport VA Medical Center (facility) in New York instructed psychotherapists to limit the number of individual psychotherapy sessions patients could receive. The OIG conducted virtual interviews from February 12 through April 9, 2026.

Background

The facility is part of Veterans Integrated Service Network (VISN) 2—New York/New Jersey VA Health Care Network—and consists of the main campus in Northport, New York, and five outpatient clinics.[1] The Veterans Health Administration (VHA) classifies the facility as a level 1c complexity.[2] The facility provides a comprehensive range of services including medicine, surgery, and mental health. From October 1, 2024, through September 30, 2025, the facility served 27,224 patients.

Mental Health Continuum of Care

VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, outlines VHA's mental health continuum of care, which "promotes timely and effective care at the least intensive level … to meet Veterans' needs."[3] The continuum ranges from least to most intensive services, starting with outpatient mental health primary care and ending with inpatient mental health treatment.

Treatment along the continuum is divided into distinct periods referred to as episodes of care. The length of an episode of care is not prescriptive and should be comprehensive and patient centered. A patient and provider use shared decision-making to determine recovery-focused measurable goals and an evidence-informed treatment plan. An episode of care ends when a patient and provider agree that goals are met, treatment is not working, or the patient no longer wants or needs care. At that point, a patient may discontinue treatment or transition to a different level within the mental health continuum of care—either stepping up to a more intensive level of the continuum or stepping down to less support, depending on the patient's needs.

[1] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated August 14, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model OPES Report Data Definition," October 1, 2023. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

Individual psychotherapy is a service on the continuum of care in which a mental health professional works with a patient to help the patient understand and change problematic feelings, thoughts, and behaviors.[4] VHA Directive 1160.05, *Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, does not define or limit psychotherapy episode-of-care time frames.[5]

Allegations and Related Concern

In December 2025, a nonprofit news organization published an article that alleged a facility leader instructed psychotherapists to limit individual psychotherapy treatment to 24 sessions and noted that two patients had their psychotherapy terminated as a result.[6] On February 9, 2026, the OIG opened a hotline inspection to review the allegation and determine whether guidance provided to facility psychotherapists regarding psychotherapy episodes of care aligned with VHA guidelines. The OIG also identified a concern with linking extended-care caseload limits to psychotherapists' performance evaluations.

Scope and Methodology

The OIG conducted virtual interviews from February 12 through April 9, 2026. The OIG interviewed leaders from the VHA Office of Mental Health; the VISN 2 mental health lead; and facility leaders, including the associate chief of staff for mental health, the psychology chief, and a mental health social work supervisor. Additional interviewees included facility psychotherapists and select staff involved in developing or implementing related facility policies. The OIG reviewed applicable electronic health record entries for patients referenced in the December 2025 article and for other patients identified by an interviewee, as well as relevant VHA and facility policies.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency standards.[7] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, email responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the

[4] "Psychotherapies," National Institute of Mental Health, accessed April 29, 2026, https://www.nimh.nih.gov/health/topics/psychotherapies; VHA Directive 1160.01.

[5] VHA Directive 1160.05, *Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, June 2, 2021.

[6] Leah Rosenbaum, "'I Feel Lost.' Anxiety Grows Among Veterans Cut off From VA One-on-One Therapy," *The War Horse*, December 11, 2025, https://thewarhorse.org/veteran-mental-health-therapy-limits-va.

[7] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not artificial intelligence-generated content. Office of Healthcare Inspections teams do not use artificial intelligence as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*"[8]

The OIG substantiates an allegation when the available evidence shows it is more likely than not that the event or action occurred. Conversely, the OIG does not substantiate an allegation when the available evidence shows it is more likely than not that the event or action did not occur. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

The OIG did not substantiate that facility leaders instructed psychotherapists to limit individual psychotherapy sessions to 24 visits. However, the OIG determined facility leaders linked psychotherapists' extended-care caseloads (patients treated beyond 24 sessions) to Focused Professional Practice Evaluations (FPPEs) for Cause, which may influence providers to factor caseload expectations into clinical decisions.

Individual Psychotherapy Sessions

The OIG found that individual psychotherapy treatment at the facility was not limited to 24 sessions. Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," issued in May 2022, established a recommended range for a typical episode of care at 8–20 sessions.[9] This policy was established after a mental health supervisor

[8] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-21-21: § 4(a), April 3, 2025.

[9] Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," May 25, 2022.

consulted the VISN mental health lead and reviewed other VA medical center policies to improve access to individual psychotherapy. Beginning in July 2024, facility psychotherapists requested more flexibility in episode-of-care lengths and extended-care caseload limits for patients with chronic high-risk needs. In March 2025, the associate chief of staff for mental health approved an updated version of Facility Standard Operating Procedure 116A-016.

The updated standard operating procedure increased the recommended range for a typical psychotherapy episode of care to "up to 24 weekly sessions." The standard operating procedure also raised the proportion of extended-care patients in a psychotherapist's caseload from "up to" 15 percent to as much as 20–25 percent, noting that psychotherapists may provide extended care when clinically indicated.[10] Additionally, the standard operating procedure changed peer consultation from a required resource for psychotherapists to an offered resource used "when a provider extends care beyond 24 sessions to allow for interdisciplinary input and appropriate treatment planning."[11]

The OIG gathered information about individual psychotherapy practices through emails and interviews with facility psychotherapists, excluding those who provided short-term therapy or therapy in a residential program setting. Of the identified psychotherapists, a majority told the OIG that although the updated standard operating procedure encouraged keeping psychotherapy episodes of care to 24 sessions, leaders were supportive when psychotherapists believed a patient required extended care. Psychotherapists who responded to the OIG email reported using the options outlined in the facility standard operating procedure when extending care, and a majority stated they did not feel pressured to terminate treatment against clinical judgment.

However, some psychotherapists described the peer consultation process as unsupportive. A few psychotherapists reported that when advocating to continue treatment, they perceived pressure from peers to terminate patients sooner than they believed was clinically appropriate and felt that voicing differing perspectives was not always well received. As a result, these psychotherapists reported hesitancy in requesting peer consultation.

During interviews with the OIG, facility mental health leaders reported an awareness that some psychotherapists continued to view the March 2025 episode-of-care guidelines as too rigid. Leaders stated they held ongoing discussions with all psychotherapists regarding the option to extend individual episodes of care beyond 24 sessions. Leaders also acknowledged that peer consultations had become contentious when practice philosophies differed, but said supervisors were available for psychotherapists to discuss cases individually as needed. The VISN mental health lead and Office of Mental Health leaders reported awareness of the facility's episode-of-

[10] Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," May 25, 2022; Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," March 1, 2025. The standard operating procedure was updated in November 2025 and kept the same expectations as the March 2025 standard operating procedure as it relates to typical episode-of-care length.

[11] Facility Standard Operating Procedure 116A-016.

care guidelines and emphasized that, because the standard operating procedure allows extended care when clinically indicated, it does not limit the number of psychotherapy sessions a patient can receive.

The OIG concluded that, although the facility standard operating procedure recommends a typical episode of care up to 24 sessions, providers may extend individual psychotherapy sessions based on clinical need. However, while many psychotherapists reported feeling supported in extending care, the peer consultation process created inconsistent experiences and, for some, contributed to reluctance requesting peer consultation.

Extended-Care Caseload Benchmarks in FPPEs

The OIG determined facility leaders linked psychotherapists' extended-care caseloads to an FPPE for Cause, which may influence providers to factor caseload expectations into clinical decisions and is inconsistent with VHA guidance.

Facility Standard Operating Procedure 116A-016, "Individual Psychotherapy Standard Episode of Care," outlines metrics of "up to" 20–25 percent proportion of a psychotherapist's caseload that may consist of extended-care patients.[12] The policy allows psychotherapists to provide additional sessions when clinically necessary, based on a patient's needs, goals, and response to treatment. When care extends beyond 24 sessions, psychotherapists are expected to document why extended treatment is needed and may seek peer consultation, as this level of care should be uncommon and reserved for patients with chronic risk, severe issues, or limited progress despite evidence-based care.[13]

The OIG learned that beginning in March 2025, the psychology chief informed psychotherapists with extended-care caseloads above 25 percent that they were being placed on an FPPE for Cause. According to VHA Directive 1100.21(1), *Privileging,* an FPPE for Cause is an oversight process evaluating a provider's privilege-specific competence when a care concern is identified. FPPEs for Cause provide a 90-day "structured monitoring program with defined benchmarks."[14]

Successful completion of an FPPE for Cause required psychotherapists to terminate care with enough patients within 90 days to meet the 25 percent threshold of patients in extended care in their caseload. Further, the FPPE for Cause stated that a failure to meet benchmarks could result in "a privileging action … including reduction or revocation. If this occurs, the facility will have to make a decision regarding your continued employment."

The psychology chief met with the psychotherapists at least twice a month during the FPPEs for Cause to discuss progress in meeting expected benchmarks and provide assistance. Several

[12] Facility Standard Operating Procedure 116A-016.

[13] Facility Standard Operating Procedure 116A-016.

[14] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

psychotherapists reported fear of failing to meet benchmarks and of the requirement to terminate patients' psychotherapy sessions within a short period. Further, the psychotherapists told the OIG they made difficult decisions about terminating patients who they believed could still benefit from psychotherapy and felt pressured to do so against clinical judgment.

The VISN mental health lead confirmed awareness of the facility's policy regarding extended-care guidelines but viewed the 20–25 percent threshold as a general framework and not a firm rule. The VISN mental health lead informed the OIG of awareness that the FPPEs for Cause had been initiated but indicated no knowledge that the actions pertained to extended care caseloads and that the VISN is not involved in the FPPE process. When the OIG described the FPPE for Cause extended-care benchmark, the VISN mental health lead said supervisors would be expected to review the complexity of psychotherapists' caseloads and continue conversations throughout the FPPE for Cause to ensure terminations of patient care were appropriate. However, the psychology chief told the OIG of not reviewing or advising psychotherapists on specific extended-care patients during the FPPEs for Cause and instead directed the psychotherapists to rely on their own clinical judgment when determining how to triage patients to other levels of care.

Office of Mental Health leaders confirmed VHA does not set limits on the number or percentage of extended-care patients on psychotherapists' caseloads. They further stated caseloads vary based on patient diagnosis and complexity and should be managed at the facility level, and that facility leaders should not impose extended-care limitations that could influence clinical decision-making.

The OIG reviewed the electronic health records of the patients named in the December 2025 article, as well as other patients the OIG identified during the inspection who may have been terminated from individual psychotherapy against a psychotherapist's clinical judgment. The OIG found that these patients were engaged in mental health care or had declined further care and no adverse clinical outcomes had occurred. For the purpose of this report, the OIG defines adverse clinical outcomes as a patient experiencing an inpatient hospitalization for psychiatric or substance use detoxification needs, a documented overdose, a suicidal behavior, or death between the termination of care and the time of review.

The OIG concluded that linking extended-care caseload expectations to FPPE for Cause benchmarks may influence psychotherapists to make treatment-length decisions based on the benchmarks rather than clinical judgment.

Conclusion

The OIG did not substantiate that facility leaders instructed psychotherapists to limit individual psychotherapy to 24 sessions. While Facility Standard Operating Procedure 116A-016 describes "up to 24 weekly sessions" as a recommended typical episode of care, the standard operating

procedure allows for extended-care based on clinical need. Many psychotherapists reported feeling supported in extending care, however, others reported hesitancy in requesting peer consultation.

Facility Standard Operating Procedure 116A-016 states the expectation that a psychotherapist's extended-care caseload is to be maintained below 25 percent. The OIG identified that facility leaders applied this expectation when evaluating psychotherapists' performance. Using extended-care caseload expectations in this manner may influence providers to factor these expectations into clinical decisions, which is inconsistent with VHA guidance. The OIG found no adverse clinical outcomes among patients whose psychotherapy was terminated.

The OIG made two recommendations to the Facility Director to evaluate the inclusion of psychotherapy extended-care caseload metrics into performance measures and to assess whether any patients discharged during a provider's FPPE for Cause experienced harm.

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and planned to implement a standardized process to review psychotherapy extended-care caseload metrics and ensure a review of cases where psychotherapy is terminated during a provider's FPPE for Cause. The OIG will follow up on the planned actions until compliance is achieved.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–2

1. The Northport VA Medical Center Director considers reviewing the inclusion of psychotherapy extended-care caseload metrics into performance measures such as Focused Professional Practice Evaluations for Cause, and takes action as warranted.

2. The Northport VA Medical Center Director considers a strategy to review patients terminated from individual psychotherapy while the psychotherapist was on a Focused Professional Practice Evaluation for Cause, determines whether any harm occurred, and takes action as warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 30, 2026

From: Executive Director, Department of Veterans Affairs (VA) Service Area 1.2

Subj: VA Office of Inspector General (OIG) Report, Review Individual Psychotherapy at the Northport VA Medical Center in New York (VIEWS 14998429)

To: Director, Office of Healthcare Inspections (54HL06)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.

2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Bruce Tucker, LCSW

[OIG comment: The OIG received the above memorandum from VHA on August 3, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 31, 2026

From: Director, Department of Veterans Affairs (VA) Northport VA Medical Center (632)

Subj: VA Office of Inspector General (OIG) Report, Review of Individual Psychotherapy at the Northport VA Medical Center in New York

To: Executive Director, Department of Veterans Affairs (VA) Service Area 1.2

1. We appreciate the opportunity to review and comment on the OIG report Review of Limiting Individual Psychotherapy at the Northport VAMC in New York. I have reviewed the documentation and concur with the response as submitted.

2. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Anthony Torggler
Executive Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on August 3, 2026.]

Facility Director Response

Recommendation 1

The Northport VA Medical Center Director considers reviewing the inclusion of psychotherapy extended-care caseload metrics into performance measures and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

VA Northport will consider the OIG's recommendation and proceed, as appropriate, with the actions that follow. VA Northport will implement a standardized process for the ongoing review of psychotherapy extended-care caseload metrics as part of provider performance oversight. Metrics will include the percentage of Veterans on extended psychotherapy caseloads, provider caseload variation, access and timeliness measures, and documentation of ongoing clinical need, with data sourced quarterly from the electronic health record and Mental Health Business Operations reports. Metrics will be reported quarterly to the Quality and Patient Safety Council, chaired by the Medical Center Director. Compliance will be monitored to ensure at least 90% adherence for two consecutive quarters.

Recommendation 2

The Northport VA Medical Center Director considers a strategy to review patients terminated from individual psychotherapy while the psychotherapist was on a Focused Professional Practice Evaluation for Cause, determines whether any harm occurred, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

VA Northport will consider the OIG's recommendation and proceed, as appropriate, with the actions that follow. VA Northport will implement strategies to ensure appropriate review of cases where individual psychotherapy is terminated during a provider's Focused Professional Practice Evaluation for Cause. Although no harm was identified during the OIG's review period, VA Northport will continue to monitor patient safety based on the OIG definition for harm. If available, aggregate data will be reviewed and presented monthly, for 6 consecutive months, to the Professional Standards Board and Executive Committee of the Medical Staff, chaired by the

Chief of Staff who reports to the Medical Center Director. Compliance will be monitored to ensure at least 90% adherence for two consecutive quarters.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Ariel Drobnes, LCSW, MBE, Director Rachelle Biddles, PhD Tabitha Eden, MSN, RN Vanessa Masullo, MD Kristina Ruskuls, MSW, LCSW Andrew Waghorn, JD
Other Contributors	Sheyla Desir, MSN, RN Christopher D. Hoffman, LCSW, MBA Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Executive Director, VA Service Area 1.2
Director, Northport VA Medical Center (632)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Kirsten E. Gillibrand, Charles E. Schumer
US House of Representatives: Yvette Clarke, Andrew Garbarino, Laura Gillen, Hakeem Jeffries, Nick LaLota, Gregory Meeks, Grace Meng, Thomas Suozzi, Nydia Velazquez

OIG reports are available at vaoig.gov.