US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

Fiscal Year 2023 Inspector General's Report on VA's Major Management and Performance Challenges

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

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.

Foreword

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, and the public by conducting effective independent oversight of Department of Veterans Affairs (VA) programs, operations, and services. Each year, the Inspector General summarizes the top management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

This year's major management challenges for VA continue to align with the OIG's strategic goals for addressing five areas of concern: (1) health care, (2) benefits, (3) stewardship of taxpayer dollars, (4) information systems and innovation, and (5) leadership and governance.

The challenges in these areas that VA must navigate in the fiscal year ahead have been identified by OIG personnel, with assistance from external oversight agencies and organizations, the veteran community, Congress, and other stakeholders. The OIG remains fully committed to identifying weaknesses that affect VA operations and its work on behalf of veterans, and then making meaningful recommendations for continuous improvement.

VA leaders face monumental challenges—both in scope and scale. At this writing, VA is struggling to implement a number of information technology systems critical to safely and promptly meeting the needs of veterans while making the best use of taxpayer dollars. Some of these systems, such as the new electronic health records system, cost billions of dollars and directly affect patient care and safety. VA also faces one of the largest benefits expansions in history, with more than four million veterans having completed screenings for toxic exposure since the PACT Act's passage. The resulting benefits backlog is anticipated to grow to 730,000 claims by April 2024 and newly connected veterans are expected to increase healthcare demands on VA as well. Although VA has hired tens of thousands of staff, it still grapples with critical shortages. Other challenges such as addressing veteran suicide (VHA's top clinical priority), maintaining timely access to quality health care across specialties both within VA and the community, and advancing fiscal controls are just some of the major management challenges oversight staff have highlighted. In addition, OIG reports reveal recurring themes and deficiencies that center around failures in VA governance and accountability.

The OIG appreciates the work VA personnel at every level do each day on behalf of veterans even as they try to navigate these many challenges.

Michael J. Missal
Inspector General

Contents

OIG Challenge #1: Healthcare Services

High-quality care demands that patients receive the necessary treatment provided by qualified clinicians in a timely manner. This is even more critical for individuals deemed to be at high risk due to their mental health and substance use conditions. The pandemic disrupted healthcare delivery in all settings, including addiction treatment, yet at the same time increased the demand for such interventions. VHA will continue to rely on community providers to deliver care when a veteran's needs cannot be met within VA's own facilities. According to internal data systems' queries that OIG has access to, VA referrals to community care have increased over 70 percent from FY 2020 to FY 2022. As of July, FY 2023 referrals have already exceeded the number of total referrals for FY 2021 and are projected to exceed FY 2022. Coordinating medical care between the VHA care system and community providers remains a challenge, particularly for managing patients with complex behavioral health needs.

Many recent OIG reports have highlighted the risks when VA personnel fail to offer care in the community as required and, even more concerning, when that care is not coordinated.

Specifically, 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 the 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 associated with patients referred to the community.

In one example of the consequences of poor care coordination for high-risk patients, an OIG review 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 evaluation and resulting targeted treatment.

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.

Further, VHA faces significant challenges in meeting the needs of individuals with substance use disorders. The devastating effects on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health issues that can place them at higher risk for suicide. Given that VHA's top clinical priority is to reduce veteran suicide, evidence-based substance use disorder treatment programs are imperative to addressing the clinical needs of these high-risk patients. When both VHA and

community care providers are engaged in managing these patients, the coordination must be seamless and collaborative.

Why This Is a Challenge

Across the community care system there is wide variability in what services are available to meet veterans' healthcare needs. This is influenced by geographic location, the disease burden of local veteran populations, medical academic institution affiliations, and other factors.

VHA has launched the Referral Coordination Initiative (RCI) at medical facilities across the country to facilitate consult scheduling for specialty care within VHA facilities and in the community, but it has struggled to implement and develop mechanisms to assess the initiative's effectiveness. The facilities have reported facing implementation challenges such as insufficient staffing and resources, unreliable wait time data, and delays in getting responses to questions. In addition, the Office of Integrated Veteran Care lacked reliable data to measure whether RCI was meeting its goal of reducing the time required to schedule appointments. The office did not assess whether staff appropriately provided patients with key information to make informed care decisions or enabled healthcare providers to spend more time with patients.

In addition, the OIG has found that VHA does not have reliable data to assess clinical and nonclinical community care staffing levels within its facilities. Many VA medical facilities reported challenges recruiting and retaining qualified medical support assistants who are responsible for processing community care referrals. Those positions require knowledge of clinical terminology and context and VA is competing with some local healthcare systems that offer higher wages and signing bonuses. The medical support assistant position was the most frequently reported Hybrid Title 38 severe shortage occupation reported by the OIG in FY 2023.

In a final example, the OIG has determined that VHA does not provide sufficient oversight for prescribing opioids to veterans despite their having a higher risk of opioid overdose than the general population. Recent OIG work shows that the Office of Integrated Veteran Care did not adequately oversee third-party administrators to ensure providers received and certified that they reviewed the Opioid Safety Initiative guidelines, nor did the office monitor third-party administrators to make certain that non-VA providers were completing prescription drug monitoring program queries as required.

Department's Corrective Actions

In a positive step forward, VA has gathered best practices on RCI implementation and posted them to an RCI SharePoint site. The Office of Integrated Veteran Care also developed and released revised RCI reference materials for VA medical facilities, including an updated guidebook, a scheduling learners' guide, scripts for discussing options with veterans, and training courses to standardize RCI execution.

However, as recommended in a recent OIG report, the Department needs to develop and implement a process that ensures timely clinical information sharing between VHA and community providers. Doing so will help ensure high-quality and safe care, coordinated support for veterans with complex and high-risk mental health diagnoses requiring multidisciplinary services, and provide support staff with clear guidance on offering every veteran all options of care.

VHA needs to improve RCI implementation by better assigning responsibilities and roles, improving training, establishing local procedures for sharing community care data for informing patients, sharing best practices among all facilities, ensuring accurate tracking of RCI consults, and developing ways to measure how well facilities meet the initiative's requirements. VHA also needs to improve the reliability of community care staffing data. It should also develop staffing reports that can be searched by service departments and assess incentives to determine whether they are effective in recruiting and retaining administrative staff.

OIG Challenge #2: Benefits for Veterans

VBA's responsibility for processing claims is at the core of providing veterans an extensive range of benefits, including military service-connected disability compensation, pension benefits, and education and vocational training, as well as compensation for eligible family members and caregivers. Claims processing often involves tremendously complicated processes, evaluations, and decision-making. Yet it is subject to challenging timelines in order to promptly provide eligible recipients with the accurate amount or level of benefits.

Challenges with benefits processing rise exponentially when eligibility is expanded or systems and processes are modernized. For example, VA has reported that since the PACT Act was passed in one of the largest benefits expansions in VA history, more than 100,000 veterans presumed to have toxic exposure for benefits consideration have enrolled in VA health care. In addition, more than four million veterans have completed toxic exposure screenings. Further, the PACT Act benefits backlog is expected to grow to 730,000 claims in April 2024. VBA's non-PACT Act claims inventory has risen to nearly 1.4 million with a backlog of more than 230,000 as of June 2023. In response, VA has expanded hiring for over 21,000 healthcare staff and 4,300 benefits personnel as it addresses the challenge of staffing shortages in multiple disciplines across the enterprise.

The PACT Act implementation has prompted a hiring surge and strategies such as automation to address the processing of claims backlogs. These actions have created many novel challenges for VA. Notably, the OIG has identified 25 high-risk areas associated with PACT Act implementation. There is also an expectation that the OIG will receive an increased number of allegations and complaints related to VA's provision of healthcare screening and care required by the PACT Act. All of this work will be conducted as key information technology systems are being modernized that have historically created additional obstacles for staff deploying them.

Why This Is a Challenge

VBA processes claims that can be exceedingly complex. VBA must process claims consistent with complicated and often unclear laws, policies, regulations, and VA procedures. Processing these claims accurately and within the mandated timelines requires continuous monitoring and oversight by VBA leaders and personnel. They must incorporate constant updates, standardize decisions for consistency, and identify errors that could affect the accuracy of the monetary benefits veterans receive.

These challenges can also be exacerbated by conditions beyond VBA's control. In FY 2023, for example, VBA was still handling a backlog of claims that flowed from the COVID-19 pandemic and anticipates an additional increase from the implementation of the PACT Act. While they are resolving claims year at a record rate—about 15 percent higher than last year on average as of June 2023—those gains were eclipsed by a record 30 percent more claims filed in the same time period, according to VA.

In addition to managing its backlog, VBA continues to struggle to interpret and implement laws and policy for managing claims and appeals—from knowing when to request medical reexaminations for veterans with claimed disabilities to ensuring complex appeals are reviewed by qualified staff. For example, VBA employees erroneously required veterans to be reexamined, even when their disabilities were permanent and not likely to improve. This subjected some veterans to unnecessary exams and travel. The employees made this error in part because VBA had not required claims examiners to cite objective evidence for why reexaminations were needed. Additionally, VBA's Compensation Service failed to contact visually impaired veterans by telephone to discuss the contents of decision notices, despite knowing since 2011 that its written products were not in compliance with section 504 of the Rehabilitation Act. Consequently, some veterans may not have been made aware of the evidence VBA required to process their claims. In addition, complex appeals were decided by VBA staff who were not designated to do so or had not completed all mandatory training because VBA's Office of Administrative Review did not monitor completed appeals to ensure they were decided by qualified staff.

With respect to personnel shortages, both VBA and VHA are struggling to hire and retain qualified personnel, despite VA having one of its best hiring years, according to VA. The OIG is required by law to conduct an annual review to identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center. In the FY 2023 review, the OIG found that all 139 VHA medical facilities that were surveyed reported at least one severe occupational staffing shortage. The total number of their reported severe shortages was 3,118, up from 2,622 the previous year. In FY 2023, even more severe occupational staffing shortages were reported by more facilities than in recent years.

Department's Corrective Actions

VBA is taking steps to better process its tremendously high volume of claims. To improve its claims processing quality, VBA is planning to use information technology system modernization and automation tools that reduce the errors inherent in manual processing. VBA anticipates automation tools will also improve claims processing efficiency by increasing the number of claims processed, shortening the time to make decisions, improving quality, and reducing the number of unnecessary examinations. In addition, VBA has updated its procedures manual to clarify which raters meet the requirements to issue decisions on complex appeals.

VBA needs to continue to implement the OIG's recommendations for improvement and better instruct VBA claims examiners. VBA should make sure that its personnel are equipped and prepared to do their jobs. VBA is responding to the OIG's recent findings that claims processors did not consistently identify relevant medical evidence for the examiner's review, did not always use clear and accurate language, did not regularly request all warranted medical opinions, and sometimes requested unnecessary medical opinions. One contributing factor was inadequate training. These failings can lead to inaccurate medical opinions, incorrect decisions on veterans' claims, delayed decisions for veterans, and an inefficient use of resources.

To address its staffing shortages, VA has engaged in surge hiring and other recruitment strategies under their expanded authority. While expedient hiring is critical, VA cannot lower its standards for suitability and expertise. VA is also responding to a recent OIG report on suitability (background) checks. In the course of auditing the personnel suitability process across all VA medical facilities, the OIG detected problems with how this process was being conducted at the VA medical center in Beckley, West Virginia. VA must be diligent in employing proper protocols to ensure staff are both qualified and suited to their positions even as they expedite hiring.

OIG Challenge #3: Stewardship of Taxpayer Dollars

The OIG has repeatedly found that VA's failure to effectively modernize its financial management systems has led to significant challenges in assuring accountability and transparency in how it obligates and expends funds. These failures in maintaining effective systems for financial management (as well as inventory tracking, patients' electronic health records management, and others discussed in the following section) have made it difficult for VA staff to effectively conduct their duties, making inefficient and ineffective use of their time and taxpayer dollars. For example, financial management system problems have significantly hampered planning of activities; ordering and tracking supplies and equipment, some of which have been found damaged or expired in storage areas; and providing oversight of the expenditure of billions of taxpayer dollars on emergent and expanded programs.

The recurring deficiencies identified by the OIG and other oversight agencies related to VA's inability to effectively implement major systems modernization have been the subject of intense congressional and media scrutiny. Although the OIG recognizes that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, their efforts are being undermined by aging legacy systems that create significant hurdles to performing their jobs and in monitoring the use of funds for personnel, purchases, and services.

VA faces the ongoing challenge of overseeing its vast spending across its enterprise. OIG reports have detailed inadequate oversight in areas such as pharmaceuticals and medical supply purchases, recovered overpayments, and purchase card use. These oversight problems have been attributed to and compounded by the Department's outdated financial management system. Although VA has initiated deployment of iFAMS (see management challenge 4), VA continues to rely on legacy financial systems, manual reconciliations, and adjustments, which has caused VA to be noncompliant with major financial management regulations. Due to VA's outdated financial management system, VA has struggled to ensure accountability and transparency in how it obligates and expends funds, particularly the supplemental funds VA received to prevent, prepare for, and respond to the COVID-19 pandemic. As the OIG reported, VA ultimately lacked assurance that funds allocated specifically for COVID-19-related purposes were being spent as intended.

Other core system failures also have significant financial consequences. For example, the Electronic Health Record Modernization program discussed in the following section was initially projected to cost $10 billion but has been revised upward of $16 billion, although based on OIG reports that amount is likely to increase. Failures in system planning, contracting, remediation, and other factors have led to long pauses, and the OIG has estimated that delays in the program's completion beyond the projected end date would cost about an additional $1.95 billion a year.

Beyond information technology systems, OIG reports have focused on significant waste that can be attributed in large part to the lack of controls, systems, and VA oversight needed to ensure products and services purchased with taxpayer funds are used efficiently and effectively.

Also, given the billions of dollars allocated for PACT Act implementation and other program expansions—including the increased payment of disability benefits and healthcare expenditures by VA—the OIG expects VA will need to be even more vigilant for identifying potential criminal activity. This creates a challenge for VA to develop greater controls for prevention of theft, misuse of funds, and fraud, and to report indicators of such activity to the OIG.

A recent example of benefits fraud was an investigation in early 2023 by the VA OIG and Social Security Administration OIG that revealed multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. The loss to VA for this single case is approximately $964,000 and the individuals involved received sentences of probation or prison time as well as an order for restitution.

Why This Is a Challenge

VA has faced significant challenges with improving its financial processes and systems—some of which result from deficiencies in information technology and lack of controls, while others are due to weaknesses in governance or the clarity of roles and responsibilities. More effective financial management is key to VA's ability to better plan, direct, monitor, and control its resources. Advances could also enhance efforts to safeguard VA assets and the timely payment of its obligations. Reliable and accurate financial information would help VA and Congress identify links between resources and results, and to understand and improve the value gained from appropriated funds.

Persistent issues require extensive efforts to change business processes, research legacy differences, and implement workarounds or more lasting solutions. Other contributing factors include questionable controls over significant program accounting estimates, decentralized and disjointed financial systems and reporting, and serious control weaknesses throughout the organization with respect to financial reporting. Attributable to a decentralized and fragmented organizational structure for financial management, these weaknesses include challenges with risk assessment and monitoring; the lack of an effective, comprehensive, and integrated financial management system; a challenging IT environment; and the reliance VA places on manual processes to identify or correct errors with financial information.

Without the deliberate and universal implementation of a centralized and testable financial management application, VA's history of noncompliance with major financial management regulations will continue.

Department's Corrective Actions

By implementing iFAMS, the Financial Management Business Transformation office reports it will increase the transparency, accuracy, timeliness, and reliability of financial information across VA. iFAMS is meant to result in improved fiscal accountability to taxpayers and strengthen the department's ability to provide care and services to veterans. Additionally, VA proposes that iFAMS will help to resolve a material weakness on its annual financial statements and increase its operational efficiency, productivity, agility, and flexibility.

The transition is exceptionally complicated—requiring intensive and continuous attention from VA—and demands strong organizational leadership and coordination. The OIG urges VA to dedicate the time and resources to resolving the early opportunities for improvement in the iFAMS transition, being vigilant in identifying challenges that will arise in the forthcoming deployments, and developing processes for timely and effective responses.

OIG Challenge #4: Information Systems and Innovation

VA is responsible for storing, managing, and providing secure access to enormous amounts of sensitive data, such as veterans' medical records, benefits determinations, financial disclosures, and education records. Safeguarding systems and networks that contain this sensitive data is essential, especially with the wide availability and effectiveness of internet-based hacking tools. Without proper measures, these systems and networks are vulnerable to groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other VA systems.

VA is in the process of modernizing a number of vital systems that are critical to its operations. VA's wide-ranging IT systems and networks are essential to providing medical care, benefits, and services to millions of veterans and their families. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as the OIG has detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by serious missteps. These have typically included weaknesses in planning, lack of stability in leadership positions, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies.

The OIG recognizes the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working tirelessly to ensure patient safety and to deliver benefits and services to eligible veterans.

Why This Is a Challenge

VA has made progress developing, documenting, and distributing policies and procedures as part of its agency-wide information security and risk management program. VA has also initiated several high-level action plans to address previously identified security weaknesses and the information technology material weakness reported as part of the Consolidated Financial Statement Audit. Still, OIG reports indicate there is much more to be done.

Information technology modernization projects have historically been very challenging for VA. The update of its patient record system has proven to be especially troubling. Perhaps the largest contract in VA history, and one that affects patient care, is VA's contract for its Electronic Health Record Modernization program. Key objectives of the new system include achieving interoperability of VA and DoD systems to provide complete health records for veterans and enhancing VA's ability to exchange records with external healthcare providers. Essential to

implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, and integrated master schedule to ensure all tasks are properly and fully completed and reported. An OIG audit found, however, that this foundational master schedule had significant reliability weaknesses, including missing tasks, no baseline schedule, and no risk analyses.

Although VA paused its Electronic Health Record Modernization rollout in June 2022, users of the new system continue to raise troubling complaints that the system hinders the delivery of prompt, high-quality patient care. The effects on staff, workload, and the risks for errors continue to be concerning.

Similarly, there are other key systems for maintaining effective and efficient VA operations in other areas that are also in critical need of updates or replacement. To modernize its financial and acquisition management systems, VA established the Financial Management Business Transformation program to replace legacy systems with the new iFAMS described above. VA maintains that iFAMS should be a streamlined, federally compliant, and cloud-hosted financial and acquisition solution with business processes and capabilities, which will help VA better comply with major financial management regulations. iFAMS implementation is intended to occur in a series of 18 waves, starting with the NCA. However, when deploying iFAMS at the NCA, the FMBT Service failed to establish comprehensive controls to reduce data reliability risks posed by a manual acquisition process and comprehensively test converted contracts. As a result, NCA contracting staff had to manually enter data in both iFAMS and the legacy system for deobligations. Additionally, iFAMS made paying some contract invoices more cumbersome. Improving risk management and system testing could help the FMBT Service prevent issues from affecting a significantly greater number of staff at VA's larger administrations and allow the FMBT Service to achieve the overall program goals.

Department's Corrective Actions

To help secure the information systems in place, VA needs to continue to address identified deficiencies within access and configuration management controls across all systems and applications. Because of the issues with the consistent application of the security program and practices across VA's portfolio of systems, VA should have adequate control and risk management procedures applied to all their systems and applications consistent with OIG recommendations.

As of September 1, 2023, of the 68 recommendations issued on VA's rollout of the new electronic health record system, 21 have not yet been implemented. Some of these have necessarily been put on hold during the follow-up contract execution and the site deployment pause that VA instituted to remediate identified problems. The open recommendations include VA minimizing the number of required mitigation strategies healthcare providers must use when the system goes live, determining whether veterans' appointments are being scheduled correctly, and addressing unresolved issues related to medication management and care coordination.

VA must more effectively engage and coordinate with all affected offices and contractors to effect needed IT and governance solutions and develop an accurate master schedule that takes into account additional anticipated delays and related costs.

VA will also need to consider how its massive information technology system modernization efforts affect one another. These system deployments are inextricably linked. For example, the iFAMS deployment will affect the inventory system upgrades, and the benefits processing system must account for the need to access the new electronic health record system. This will require VA to not only take into account the individual users of each new system, but how they will affect other deployments.

OIG Challenge #5: Leadership and Governance

The OIG's oversight reports often reveal recurring themes and deficiencies that center on the key elements of accountability. For example, healthcare facilities committed to patient safety should follow protocols that prioritize high-quality care and have a structured and proactive quality and safety management oversight team. OIG reports, however, routinely identify instances in which staff fail to adhere to policy or to take actions that ensure a culture of patient safety. In recent years, the OIG has also found failures of leadership and governance across VA, to include VBA and the NCA. This included OIG findings of deficiencies with the physical security of medical facilities, faulty claims processing for military sexual trauma claims, and the inadequate and ineffective administration and oversight of the final disposition of veterans' unclaimed remains, the latter of which responsibility spanned all three agencies.

A recent OIG healthcare oversight report found that the Tuscaloosa VA Medical Center and VISN 7 had insufficient oversight of the facility's Patient Safety Program. The OIG received a VHA Issue Brief identifying concerns with the program's management personnel not completing the required patient safety root cause analyses and risk assessments, and the former patient safety manager not attending meetings with facility and VISN committees. These concerns followed the extended leave and abrupt retirement of the former patient safety manager. The OIG substantiated the concerns and identified other issues with program oversight and the facility's culture of safety. Facility leaders failed to fully engage with Patient Safety Program staff and did not sufficiently use available tools to assess and evaluate reported concerns that put patients at unnecessary risk.

Other OIG reports have identified when leaders' delays in responding to concerns related to the competency of healthcare providers put patients at risk. A report on the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana, highlights this issue. The cardiology nursing staff had expressed multiple concerns to facility leaders regarding the skills of a newly trained interventional cardiologist. As a result, the cardiologist's cardiac catheterization laboratory privileges were suspended and a fact-finding investigation was initiated. However, these actions were not completed in a timely manner. The fact-finding investigation was finalized more than

three months after the cardiologist's suspension, and it took almost another three months for the cardiologist's privileges to be reinstated so that leaders could initiate a second observed evaluation of the cardiologist's performance in the catheterization laboratory. After six months out of practice, the cardiologist refused to participate in a practice review and resigned. Ultimately, the OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility.

Why This Is a Challenge

VA leaders at every level often do not consistently get the information they need to make effective decisions and, in some cases, fail to take necessary and prompt action when they do. Leaders and managers often struggle to create a culture and environment in which every employee feels empowered to report problems. Frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

The OIG's recent report on the mistreatment of a patient admitted to the Miles City Community Living Center, part of the VA Montana Healthcare System in Fort Harrison, describes failures in leadership that led to several incidents of patient abuse. The OIG learned that nurses and a physical therapist forced a critically ill patient to walk. The patient first verbally refused to walk and then went down to the floor to further refuse participation. Staff reported that the physical therapist and a nurse forcefully lifted the patient by the arm to stand and then pulled the patient's walker forward and out of reach, compelling the patient to walk. A VA police report documented bruises to the patient's arms, and staff told the OIG that the patient sustained skin tears during this session. The OIG concluded that the physical therapist and nurses violated VHA policy by failing to respect the patient's right to refuse treatment and subjecting the patient to mistreatment during two physical therapy sessions while critically ill. The OIG also determined that there were three previous investigations with confirmed findings of mistreatment or abuse in the community living center. Two nurses involved in the mistreatment of this patient were also involved in two of the other incidents, one in a 2018 incident and both in an August 2020 incident. The OIG determined that facility leaders did not complete oversight processes for the community living center, including intervening in prior findings of community living center patient mistreatment in 2018 and 2020. Facility leaders also failed to oversee the sole physician responsible for the community living center patients. The lack of oversight repeatedly placed patients at risk.

This case reflects the kind of conditions the OIG has found in other VA medical facilities that did not foster the prompt and candid reporting of concerns. Leaders' failures to create a culture in which personnel feel safe in reporting clinical personnel's incompetency or errors can lead to tragic outcomes.

Department's Corrective Actions

There is no question that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. They often have to navigate obstacles and overcome challenges to make certain that patients receive prompt high-quality care and that veterans and other eligible beneficiaries receive the compensation and services they have earned. Unfortunately, the OIG has found that despite VA efforts to protect whistleblowers and encourage continuous improvement and accountability, some leaders and personnel continue to struggle with implementing the key components of accountability. This is a theme demonstrated throughout these major management challenges as causes for deficiencies.

Leadership within an organization the size of VA is complex, and there is not a single solution that covers all circumstances. However, OIG testimony and related report recommendations include creating a strong governance and clarity of roles and responsibilities; ensuring adequate and qualified staffing; employing updated IT systems and effectual business processes; requiring effective quality assurance and monitoring; and providing stable leadership that fosters responsibility for actions and continuous improvement. OIG reports often provide specific recommendations related to governance and leadership as part of its examination of the causes for identified problems. Even if they only apply to a single facility, office, or program area, they should be considered across the enterprise.

VA Management's Response
VA acknowledges the challenges presented in the OIG report and appreciates the IG's dedication to identifying opportunities for improvement in VA programs and operations. For additional information on management's response and the measures VA is implementing to address each challenge, refer to the individual IG reports related to each challenge as provided in the previous table.[1]

[1] See the appendix for the table of related VA OIG reports.

Appendix: Related Reports and Congressional Testimony

See selected related reports and Congressional testimony below that support VA's FY 2023 Major Management Challenges. All VA OIG reports are available at www.vaoig.gov.

		Challenge				
Related Reports	**Date**	**#1**	**#2**	**#3**	**#4**	**#5**
Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative	10/27/2022	X				
Audit of VA's Financial Statements for Fiscal Years 2022 and 2021	12/7/2022			X	X	
VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments	12/8/2022		X			
Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	1/17/2023	X				X
Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics	1/18/2023				X	
Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama	1/18/2023				X	
Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System	1/31/2023	X				X
Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison	1/26/2023	X				X
Financial Efficiency Inspection of the Palo Alto Health Care System in California	2/2/2023			X		

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Financial Efficiency Inspection of the Northern Arizona VA Health Care System	2/8/2023			X		
Security and Incident Preparedness at VA Medical Facilities	2/22/2023					X
Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia	2/23/2023					X
Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama	2/27/2023	X				X
VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff	3/9/2023		X			
Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits	3/16/2023		X			
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona	3/23/2021	X				X
Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met	3/28/2023				X	
Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic	4/11/2023			X		
VHA Can Improve Controls Over Its Use of Supplemental Funds	5/9/2023			X	X	
Federal Information Security Modernization Act Audit for Fiscal Year 2022	5/17/2023				X	

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Goals Not Met for Implementation of the Beneficiary Travel Self-Service System	5/31/2023		X		X	
Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania	6/7/2023				X	
Compensation and Pension Benefits Claims Backlog Issue Statement	6/8/2023		X			
Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota	6/8/2023				X	
Financial Efficiency Inspection of the NY Harbor VA Health Care System	6/14/2023			X		
Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff	7/19/2023	X				
OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023	8/22/2023	X				X
Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee	9/3/2020	X				X
Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	9/27/2022	X				X

Related Congressional Testimony	Challenge #1	#2	#3	#4	#5
Statement of Deputy Inspector General David Case – VA's Electronic Health Record Modernization: An Update On Rollout, Cost, and Schedule – September 21, 2022				X	X
Statement of Inspector General Michael Missal – Hearing on "How the OIG Enhances Accountability at VA" – February 28, 2023					X
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on "Combatting a Crisis: Providing Veterans Access to Life-Saving Substance Abuse Disorder Treatment" – April 18, 2023	X				X
Statement of Inspector General Michael Missal – Hearing on "COVID-19 Supplemental Funding: Did it Protect and Improve Veteran Care" – May 23, 2023	X		X		X
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on "Care Coordination: Assessing Veteran Needs and Improving Outcomes" – June 13, 2023	X				X
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on "Connections to Care: Improving Substance Use Disorder Care for Veterans in Rural America and Beyond" – June 14, 2023	X				X
Statement of Nicholas Dahl, Deputy Assistant Inspector General, Office of Audits and Evaluations – Hearing on "The Status of VA's Financial Management Business Transformation" – June 20, 2023				X	X
Statement of Deputy Inspector General David Case – Hearing on "Pending Legislation" – July 12, 2023					X
Statement of Stephen Bracci, Director, Claims and Medical Exams, Office of Audits and Evaluations – Hearing on "VA Disability Exams: Are Veterans Receiving Quality Service?" – July 27, 2023		X			X