# SEPTEMBER 2024 HIGHLIGHTS

## Congressional Testimony

The OIG actively engages with Congress on issues affecting VA programs and operations. The OIG's participation in congressional hearings helps focus legislative action and elevates national attention on topics of concern within the veteran community. In September, OIG leaders testified in the following five hearings before the House Committee on Veterans' Affairs (HVAC), as well as submitted a statement for the record for a sixth HVAC hearing. All of their written statements can be found on the OIG website. The hearings can be viewed on the committee website.

### Inspector General Testifies on the OIG-Identified Foundations of VA Accountability

Inspector General Michael Missal's September 10 testimony before the full committee focused on the need for VA to improve the five core elements of accountability that reflect effective leadership. During the hearing, Mr. Missal noted breakdowns in some or all of those core elements—strong governance, processes, staffing, IT and other infrastructure systems, and quality assurance—found in recent healthcare inspections of VA medical centers such as Hampton, Virginia, and Aurora, Colorado. He also attributed failures in accountability that are highlighted in recent OIG reports related to the VBA disability exams process; improperly awarded critical skills incentives to VA central office executives; and the pause of the Program Integrity Tool used for community care claim billing and to detect fraud, waste, and abuse. In response to questions, Mr. Missal explained the impacts of these accountability weaknesses, particularly around increased risks to patient safety and the stewardship of VA resources.

### Principal Deputy Assistant Inspector General for Healthcare Inspections Testifies on Oversight of VHA's Veterans Crisis Line

Dr. Julie Kroviak's testimony before the Subcommittee on Health on September 18 detailed the findings of a recent report on the Veterans Crisis Line's transition to a three-digit dialing code, as well as a 2023 report concerning a veteran's suicide after an inadequate suicide risk assessment by a Veterans Crisis Line responder. In response to questions, Dr. Kroviak noted the need to continue implementing quality assessment processes that regularly review responders' performance and the need to ensure Veteran Crisis Line staff are supported by supervisors.

### Director of the Community Care Division Testifies on VHA's Program Integrity Tool

At a September 19 hearing before the Subcommittee on Technology Modernization, Dr. Jennifer L. McDonald testified on the impact that VHA's pause in using its Program Integrity Tool has had on community care revenue collections and oversight operations.

Dr. McDonald discussed data integrity and accuracy issues, as well as the challenges VHA faces in billing private insurers for community care and how this has affected veterans who may receive bills for copayments more than a year after treatment. The OIG estimated that the Program Integrity Tool's pause has resulted in approximately $665.5 million in Revenue Operations collections that had not been recovered from February 1, 2023, through February 1, 2024. In response to questions, she highlighted the OIG's July 2024 management advisory memorandum, which detailed actions VHA should take to address the problems resulting from the Program Integrity Tool's pause and to prevent future disruptions to revenue collections.

### Deputy AIG for Healthcare Inspections Testifies on Issues Identified at the Hampton VA Medical Center

Dr. Jennifer Baptiste testified before the Subcommittee on Oversight and Investigations, about recent healthcare inspection reports detailing serious issues at the Hampton VA Medical Center in Virginia. The three reports uncovered lapses in care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. These failings contributed to increased risks to patient safety and adverse outcomes. She also discussed the role of the Veteran Integrated Service Network (VISN) in monitoring and supporting troubled facilities. During the hearing, her responses to questions noted that Hampton leaders did not create an environment that fostered individual responsibility and continuous improvement and they lacked a basic understanding of the processes that support the delivery of safe health care. She also emphasized the need for a more proactive role for all VISN leaders to ensure facilities are appropriately monitored and have the resources needed to provide high-quality healthcare.

### Deputy Assistant Inspector General for Management and Administration/Chief Information Officer Testifies on the Veterans Benefits Administration's Digital GI Bill Platform

Nicholas Dahl testified on September 26 before the Subcommittee on Economic Opportunity regarding the findings of a recent OIG report on VBA's oversight of the Digital GI Bill platform, a system designed to improve education benefits delivery. Mr. Dahl discussed how inadequate planning led to underdeveloped and unrealistic contract requirements and terms that resulted in significant delays and more than doubled the original contract cost. The management failures that the OIG identified are similar to those identified in other IT modernization projects observed across the department. In response to questions, Mr. Dahl discussed actions VBA must take to implement the OIG's recommendations.

### Inspector General Provides a Statement for the Record on VBA's Contract Medical Exam Program

Inspector General Missal published a statement for the record for the congressional hearing, *Examining VA's Challenges with Ensuring Quality Contract Disability Compensation Examinations,* held by the Subcommittee on Disability Assistance and Memorial Affairs on September 18. His statement focused on several reports the OIG has published in recent years that highlight ways VBA can improve the oversight of the contract exams used in the processing of veterans' compensation and pension claims. These reports address concerns with quality assurance; the lack of accessibility, safety, and cleanliness of some contract exam facilities; and adherence to requirements related to veterans' options for the distances traveled to exams.

## Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments in September.

### Healthcare Investigations

#### Medical Supply Company President Sentenced for Role in Kickback Scheme

A VA OIG investigation revealed a former medical supply company owner paid kickbacks of over $36,000 to a former central supply department supervisor at the Jesse Brown VA Medical Center in Chicago in exchange for their initiation and approval of orders from his company for products that were never delivered to VA. The former medical supply company owner was sentenced in the Northern District of Illinois to 24 months in prison and 24 months of supervised release after pleading guilty to wire fraud. The former VA supervisor was previously sentenced to 84 months in prison and 36 months of supervised release. Both defendants were ordered to jointly pay restitution to VA of over $1.7 million.

### Benefits Investigations

#### Nonveteran Pleaded Guilty to Stealing Over $450,000 in VA Compensation Benefits from a Disabled Veteran

A multiagency investigation revealed that a nonveteran deposited into his personal bank account at least four stolen VA disability checks that were intended for a hospital-bound veteran diagnosed with amyotrophic lateral sclerosis (ALS). After the bank refused to deposit the checks

due to a name mismatch, the individual and a coconspirator used stolen identity documents to open another bank account in the victim's name and then successfully made the deposits. Between 2015 and 2020, the individual and his coconspirator stole approximately $450,000 in VA disability benefits checks intended for the veteran. The nonveteran pleaded guilty in the District of Massachusetts to theft of government benefits and conspiracy to steal government benefits. The VA OIG, US Postal Inspection Service, and Social Security Administration OIG conducted this investigation.

### VBA Quality Review Specialist Pleaded Guilty to Theft of Government Funds

Between December 2019 and August 2022, a VBA quality review specialist at the St. Paul VA Regional Office created 21 false VA claims in the names of multiple VA beneficiaries and then directed the resulting payments to his personal bank accounts. The total loss to VA was approximately $389,000. The defendant pleaded guilty in the District of Minnesota to theft of government funds. As a stipulation of the plea deal, he agreed to be terminated from VA and to pay full restitution. The VA OIG investigated this case.

### Daughter of Deceased VA Beneficiary Indicted for Wire Fraud

Another VA OIG investigation resulted in charges alleging that the daughter of a deceased VA beneficiary continued to collect and withdraw her mother's VA Dependency and Indemnity Compensation benefits following her death in November 2005. She was arrested after being charged in the Middle District of Florida with wire fraud. The loss to VA is about $338,000.

### Veteran Indicted for Benefits Fraud Scheme

According to a joint investigation by the VA OIG and Social Security Administration OIG, a veteran allegedly made materially false statements regarding his ability to work due to his service-connected disabilities, while simultaneously being gainfully employed and receiving VA individual unemployability benefits and Social Security Disability Insurance benefits. The veteran was indicted in the District of Montana on charges of false statements, including false statements to the Social Security Administration. The total loss to the government is over $454,000. Of this amount, the loss to VA is about $150,000.

### Former VA Fiduciary Pleaded Guilty to Stealing VA Funds Intended for Veteran

The son of a veteran who previously served as his VA-appointed fiduciary withdrew almost $80,000 in cash without permission that was intended for his father from the fiduciary account. He then refused to provide VA's fiduciary hub with any accounting of the funds during his time as fiduciary and eventually cut off communication with VA and his father. The defendant pleaded guilty in the Northern District of Mississippi to theft of government funds. The VA OIG conducted this investigation.

## Investigations Involving Other Matters

### Business Owner Sentenced for Paycheck Protection Act and Economic Injury Disaster Loan Scheme

The VA OIG and IRS Criminal Investigation found that the owner of a tax and accounting services business prepared false tax documents that assisted others to fraudulently obtain Small Business Administration–backed Paycheck Protection Program (PPP) and Economic Injury Disaster Loans (EIDL) for nonexistent or defunct businesses. The total loss to the government is approximately $1.2 million. The business owner was sentenced in the Eastern District of Louisiana to 60 months of probation and restitution of almost $485,000 after pleading guilty to false statements, theft of government funds, fraud, and false statements to the IRS. This investigation was the result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC). As a PRAC member, the VA OIG assists federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

### Plumbing and Heating Company Owner Pleaded Guilty to Economic Injury Disaster Loan Scheme

According to an investigation conducted by the VA OIG and FBI, the owner of a plumbing and heating company obtained an EIDL loan for his company for approximately $1.2 million. The loan agreement stipulated that the owner would use all the loan proceeds as working capital for his company to alleviate economic injury caused by the COVID-19 pandemic. He subsequently used a portion of these funds for personal purposes, to include purchasing a diamond ring for approximately $83,000 and spending over $96,000 for remodeling services for his home. The business owner pleaded guilty in the District of Massachusetts to theft of government property. This investigation, which does not have a nexus to VA programs and operations, was also the result of a referral from the PRAC.

### Spouse of VA Employee Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans

A multiagency proactive investigation revealed the spouse of a VA employee submitted false and fraudulent payroll, revenue, and other information associated with three purported businesses to obtain PPP and EIDL loans totaling over $368,000. The spouse was sentenced in the Eastern District of Washington to 12 month in prison, 36 months of supervised release, and restitution of about $402,000 after pleading guilty to presenting false, fictitious, or fraudulent claims. The VA OIG and the US Attorney's Office for the Eastern District of Washington's COVID Benefits Fraud Task Force conducted this investigation with assistance from the Small Business Administration OIG, FBI, and IRS Criminal Investigation.

# Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The office released the following reports in September.

## Benefits

### Featured Report

#### VBA's and NCA's Personnel Suitability Programs Need Improved Governance

The OIG conducted this audit to evaluate the background investigation process for VBA and NCA staff and determine whether actions were completed on time and recorded reliably. Among its findings, VBA and NCA did not ensure background investigations were completed within required time frames or recorded reliably. The team found problems at every stage of the background investigation process. Delayed adjudications were especially problematic. About 71 percent of VBA employees and 58 percent of NCA employees were not adjudicated by VA within the required 90 days of the date of the final investigative report. As a result of program deficiencies, both administrations assumed unnecessary risk by allowing staff who were not fully vetted to handle sensitive personal information and interact with veterans.

## Healthcare Access and Administration

#### Alleged Mismanagement of Contracts for Wheelchair-Accessible Transportation Services by the Health Administration Service at the Dallas VA Medical Center in Texas

VA's Veterans Transportation Program offers travel solutions for veterans to get to and from VA healthcare facilities at little or no cost to veterans. Transportation by wheelchair van is one travel option, and VA's Health Administration Service is responsible for administering the contracts that provide it. The OIG review was prompted by a hotline referral that alleged mismanagement of contracts for wheelchair transportation services at the Dallas VA Medical Center. The OIG substantiated the allegation and found that staff overpaid approximately 30 percent, or $3.7 million, to the contractor for mileage overcharges and duplicate invoices. Insufficient invoice review and approval by certifying officials contributed to these errors going unaddressed. VA concurred with the OIG's two recommendations related to establishing policy to improve invoice reviews and to recovering the $3.7 million in overpayments.

### Cardiothoracic Services Contracting at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, Needs Improvement

The OIG reviewed the practices of Network Contracting Office (NCO) 12 related to cardiothoracic services at the Captain James A. Lovell Federal Health Care Center. The OIG team found that NCO 12 bypassed the Medical Sharing Office/Affiliate National Program Office review process for cardiothoracic services contracts at the facility by regularly awarding short-term contracts since 2012 to avoid a lapse in service. As a result, the contracts did not undergo technical, legal, and clinical reviews. Although NCO 12 did not violate VHA policy, the OIG found that contracting officials were not effective at ensuring their strategies for acquiring cardiothoracic services at Lovell were in the best interest of the government and in keeping with the latest VA clinical care standards. The OIG made four recommendations to correct the deficiencies identified.

### VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents

This audit determined that VA and Oracle Health did not have adequate controls to prevent electronic health record (EHR) system changes from causing major performance incidents, to respond to those incidents uniformly and thoroughly, or to mitigate their impact through standard procedures and interoperable downtime equipment. Further, VA had no formal process to link reports of patient care delays to specific major performance incidents. Ultimately, the inadequate controls stemmed from the initial May 2018 contract. In May 2023, VA modified the contract to strengthen some requirements but could do more. The EHR system's estimated cost was originally $16 billion. Without better controls, incidents will continue, leading to further costly delays and risking patient safety.

### A Hiring Initiative to Expand Substance Use Disorder Treatment Needed Stronger Coordination, Planning, and Oversight

In fiscal year (FY) 2022, VHA launched a multiyear hiring initiative to expand veterans' access to substance use disorder treatment. The OIG conducted this review to assess whether medical centers met the FY 2022 goal of hiring 90 percent of approved positions. The OIG found that for FYs 2022 and 2023 combined, medical centers had only hired 837 people (65 percent of the first year's goal) and spent $97 million of the $267 million intended for the initiative. Remaining funds were spent on allowed purposes, retained by medical centers for unspecified purposes ($14 million), or returned to the finance office. In addition to external factors, VHA's failure was due to not clearly communicating hiring priorities, not defining and assigning responsibilities for implementation and oversight, and lacking accountability for achieving the initiative's goals. VHA concurred with the OIG's three recommendations to ensure the $14 million for unspecified purposes was properly spent and to address identified deficiencies.

### Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management

This audit assessed whether VA's VISNs were effectively overseeing the supply chain management conducted by their medical facilities. Supply chain management is critical to preventing waste and ensuring unexpired medical products are available for patient care when needed. An audit team's data assessment of 140 quality control reviews conducted by VISN supply chiefs in FY 2023 revealed medical facility noncompliance with policy in about 18.5 percent of required areas. The OIG team also visited six medical facilities, three of which had not corrected 127 of the total 130 outstanding deficiencies. This was partly due to staffing vacancies, leadership turnover, insufficient VISN support, and inadequate storage space. The team also found instances in which surgeries were delayed or canceled because supplies were unavailable, VISN supply chiefs did not report all noncompliant practices, and program office monitoring was inadequate. VA concurred with the OIG's six recommendations related to improving VISN oversight of facility supply chain management.

### Additional Controls Are Needed to Improve the Reliability of Grant and Per Diem Program Data

A review team examined whether VHA has reliable data to monitor grantee performance, veteran outcomes, and progress under the Grant and Per Diem Program. Within this program, grantees provide veterans with temporary housing, assistance obtaining permanent housing, and supportive services such as mental health and substance use disorder treatment. The review team estimated that outcome data were unreliable for about 21 percent of veterans recorded as having exited the program for permanent housing. The data did not match VA medical records, did not align with the grantee's records, or lacked supporting documentation. In addition, the data did not capture all instances of veterans being discharged from the program under negative circumstances. Although VHA took steps to improve data reliability, additional controls would improve leaders' ability to make informed decisions on the services unhoused veterans need and allow VA to hold grantees accountable for improving their services for veterans.

### Independent Review of VA's Special Disabilities Capacity Report for FY 2022

VA must submit an annual report to Congress documenting its capacity to provide specialized treatment for veterans with spinal cord injuries and disorders, traumatic brain injury, blindness, prosthetics and sensory aids, or mental health issues. Congress requires the VA OIG to report on the accuracy of these VA reports. This OIG report identified minor errors and data omissions in the FY 2022 capacity report. VA cannot report mental health capacity data because of changes to the definition and tracking of treatment outcomes. The capacity report does not capture community care data or changes in bed capacity at VA's centers for spinal cord injuries and disorders. In addition, VHA reported the wrong spending data for traumatic brain injury at the

network or geographic service area level. Finally, the transition to the Oracle Cerner EHR has affected the completeness of some facility, network, and nationally reported data elements.

### Action Needed to Ensure VA Meets Staffing and Vacancy Reporting Requirements under the MISSION Act of 2018

The OIG assessed VA's compliance with the MISSION Act of 2018, which requires VA to publish quarterly staffing and vacancy reports. The act also requires the OIG to review VA's data-reporting website. According to the OIG's assessment, VA complied with specified staffing and vacancy reporting requirements. However, in its 2023 annual report, VA did not address the steps it took to improve the onboarding process at medical facilities that exceeded time-to-hire metrics. Furthermore, the OIG determined VA could improve reporting on its public website by clarifying the reason for reporting vacancies as funded and unfunded, defining the scope of data for annual reports, and ensuring that data sources are described consistently across written procedures and published reports. VA concurred with the OIG's recommendation to include onboard timeline improvement steps in future annual reports.

## Financial Efficiency

### VHA Needs to Establish Controls for Its Ambulatory Care Budget Estimate

Most VHA health care is delivered in outpatient settings (known as ambulatory care). Because over half of VHA's medical care budget is for ambulatory care (about $65.1 billion for FY 2023), the VA OIG conducted this audit to determine whether VHA has adequate controls over its budget formulation process to ensure its ambulatory care budget estimate is reliable. The OIG found that VHA lacks documented procedures, including assigned roles and responsibilities, for developing the ambulatory care budget estimate. VHA also did not establish a data governance structure that includes authoritative data sources and assigned data stewards to help establish data management procedures. Documented procedures and a data governance structure could help maintain organizational knowledge of the process and provide reasonable assurance that VHA's internal controls over operations, reporting, and compliance are effective. The OIG made four recommendations to strengthen internal controls over the budget formulation process.

### A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2023 on VA Federal Supply Schedule Pharmaceutical Proposals

The federal government spends billions of dollars annually on pharmaceutical items through VA's Federal Supply Schedule (FSS) program. To help VA negotiate fair and reasonable prices for the government, the OIG examines and reports on pharmaceutical proposals submitted to VA for FSS contracts that have an anticipated annual value expected to exceed $5 million. This review summarizes the 17 nonpublic oversight reports the OIG completed in FY 2023 regarding

pharmaceutical FSS proposals, which had a cumulative 10-year estimated contract value of approximately $19.5 billion.[1] Of $120.6 million the OIG identified in contract savings over the 10-year life of the contracts, VA contracting officers obtained and saved taxpayers more than $351,000.

### A Summary of OIG Preaward Contract Reports Issued in Fiscal Years 2022 and 2023 on VA Federal Supply Schedule Nonpharmaceutical Proposals

The OIG also reviews nonpharmaceutical proposals submitted to the VA National Acquisition Center for FSS contracts to help VA contracting officers negotiate fair and reasonable prices. Contracting officers can use OIG price recommendations on submitted proposals to negotiate better prices than those offered. This report summarizes the 43 preaward reports provided to VA contracting officers by the OIG during FYs 2022 and 2023 on nonpharmaceutical FSS proposals. Altogether the reviewed proposals covered six supply schedules, had a cumulative estimated contract value of about $1.6 billion for FY 2022 and $1.2 billion for FY 2023, and involved 41,398 offered items. Contract negotiations for 40 of the 43 nonpharmaceutical proposals had been completed as of May l, 2024, and the OIG's recommendations collectively assisted contracting officers in obtaining $49 million in contract savings for VA over the life of the contracts.

### A Summary of Reviews in Fiscal Years 2022 and 2023 of Manufacturers' Noncompliance with Veterans Health Care Act Provisions on Pharmaceutical Pricing

In line with the Veterans Health Care Act of 1992, the OIG reviews whether certain manufacturers (1) made all their covered drugs available at a discount to the government through an FSS contract and (2) correctly calculated and reported the drugs' non-federal average manufacturer price on which the discount is based. The law helps ensure the government receives fair prices on pharmaceutical purchases. Although the OIG's reviews are not published due to sensitive commercial information, this report anonymously summarizes the 15 reviews completed in FYs 2022 and 2023. Cumulatively, the OIG identified approximately $61.2 million in overcharges by manufacturers to the government. VA has since collected approximately $59.3 million (about 97 percent) of the recommended amount.

### Summary of Fiscal Year 2023 Preaward Audits for Healthcare Resource Proposals from Affiliates

Contracting officers must request an OIG review or audit for sole-source healthcare proposals with an anticipated annual value of at least $400,000. In FY 2023, the OIG completed 15 audits

[1] The underlying OIG reports on the individual proposals are not published because they contain sensitive commercial information that is protected from release under federal law.

of proposals with a combined estimated value of about $125.8 million, identifying about $37.3 million in potential savings. Following the audits, the VHA sustained about $9.2 million in cost savings. For 13 proposals with full-time-equivalent pricing, the prices offered to the government for hourly rate pricing were higher than supported amounts. Two proposals had full-time-equivalent and per-procedure pricing, offering per-procedure rates higher than Medicare rates. Finally, the OIG found potential conflicts of interests in 10 of the 15 proposals reviewed.

### Independent Audit Report of a Dialysis Provider's Contract Pricing and Billing Compliance

After previously identifying concerns in pricing accuracy and local billings for a dialysis contractor, the OIG conducted this audit to determine whether the contractor complied with billing terms and conditions. In the OIG's opinion, except for instances of incorrect billings to local VA facilities, the contractor's assertion that it billed in accordance with the terms and conditions of its old and new contracts is fairly stated in all material respects. However, the OIG found the contractor incorrectly received almost $6.4 million by improperly billing local VA facilities. According to the contractor, it had stopped local billings and begun providing refunds. However, not all facilities the OIG contacted were able to confirm these refunds at the time of the audit. The OIG made two recommendations to the contracting officers: Request that the contractor perform a self-audit of local VA claims and verify that the contractor has refunded the claims.

### Fiscal Year 2023 Risk Assessment of VA's Charge Card Program

The OIG conducted an annual risk assessment of VA's purchase cards for supplies and services; travel cards for official travel expenses; and fleet cards for fuel, maintenance, and repair of government-owned and -operated vehicles. These charge card programs had over $5.6 billion in spending from July 1, 2022, through June 30, 2023. The OIG conducted this risk assessment from August 2023 through January 2024. The OIG determined VA's Purchase Card Program is at medium risk of illegal, improper, or erroneous purchases. Data analysis, the volume and value of spending, and OIG investigations and reviews identified patterns of purchase card transactions that deviate from the Federal Acquisition Regulation and VA policies and procedures. In contrast, VA's Travel and Fleet Card Programs have a low risk of illegal, improper, or erroneous purchases based on the data analysis and lack of related additional risk factors.

### VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2024

The VA Transparency & Trust Act of 2021 requires the OIG to submit semiannual reports comparing how VA is obligating and expending covered funds to the planned obligations and expenditures. In its sixth semiannual report, the OIG found that while VA appropriately obtained

congressional approval for American Rescue Plan (ARP) Act spend plan deviations, VA did not always meet deadlines for submitting biweekly and quarterly reports. The OIG also found that VA generally complied with its obligation policy by submitting quarterly reviews and that the reviewed open obligations met ARP Act requirements. However, VA did not consistently provide explanations as required for obligations that were older than 90 days or that had no activity for 90 days. VA concurred with the OIG's recommendations to confirm that reports are being submitted to Congress as required by law and within the mandated timeframes, as well as to ensure staff know and understand VA financial policy requirements for the review of open obligations included in quarterly obligation reports.

### Financial Efficiency Inspection of the VA Pittsburgh Healthcare System

The OIG inspected the following financial activities and administrative processes at the VA Pittsburgh Healthcare System: managerial cost accounting, open obligations oversight, purchase card use, and supply chain management. The OIG found that the healthcare system

- did not consistently use managerial cost accounting information to improve efficiency, reduce costs, and make business decisions;
- did not fully comply with VA policies on obligations oversight, resulting in an estimated $87,000 that could have been put to better use and about $63,000 from accruals that were not reviewed and canceled in a timely manner;
- may have incurred about $403,000 in questioned costs because of split purchases on purchase cards; and
- did not use supply chain management operations sufficiently to ensure days-of-stock-on-hand metrics were met or supply chain data were accurate. Facility leaders reported staffing shortages may have affected local oversight.

The OIG made six recommendations to the healthcare system director, which, left unaddressed, may eventually interfere with financial efficiency practices and the stewardship of VA resources.

### Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System

In this second financial inspection, which assessed the VA Northeast Ohio Health Care System across the same four financial activities and administrative processes, the OIG found the facility's use of managerial cost accounting information does not fully align with federal financial accounting standard practices regarding performance measurement, budgeting, cost control, and making economic decisions. The healthcare system also did not always review open obligations and deobligate funds no longer needed, and did not always process purchase card transactions in accordance with VA policy. Additionally, the OIG noted the healthcare system

could benefit from improving the efficiency of inventory oversight by ensuring inventory values are recorded correctly in the Generic Inventory Package. VA concurred with the OIG's 10 recommendations for improvement.

### Follow-up Financial Efficiency Inspection of the Southeast Louisiana Veterans Health Care System in New Orleans

The OIG previously inspected the healthcare system in 2021 and made six recommendations for corrective action. This follow-up inspection reassessed the same financial activities and administrative processes and identified issues with Medical/Surgical Prime Vendor program use, purchase card use, and pharmacy operations. In each area, the healthcare system made limited progress improving issues identified in the OIG's 2021 inspection report. The inspection team found that the healthcare system took steps in addressing administrative staffing efficiency, but identified opportunities for further improvement. The OIG reiterated four recommendations from the 2021 inspection for which the plans to address the recommendations had not been fully implemented, and added seven recommendations to help officials improve performance.

## Information Technology

### VA Continues Moving Toward Full Compliance with Geospatial Data Responsibilities for a Covered Agency

This audit was conducted by the OIG to determine whether VA complied with the law governing geospatial data and to follow up on recommendations from its previous report, which detailed VA's noncompliance with three requirements for covered agencies. Since then, VA has continued to move toward compliance. For this audit, the OIG found VA was not compliant with two of the 12 requirements. VA concurred with the OIG's two recommendations, the first of which is to reevaluate and determine whether the VHA Geographic Information System's security categorization level should be changed to moderate based on the personally identifiable information in the system. The second recommendation was to reassess whether identified security incidents constituted a breach and to instruct staff associated with the incident response process that each security and privacy incident must be captured on a separate Privacy Security Events Tracking System ticket.

### Follow-Up Information Security Inspection at the Southwest Consolidated Mail Order Pharmacy in Tucson, Arizona

The purpose of this follow-up inspection was to determine whether information systems at the Tucson mail order pharmacy were meeting federal security guidance. The OIG inspected the facility in 2021 and made six recommendations to correct security weaknesses. During this inspection, the team identified continuing deficiencies related to configuration management, security management, and access controls. Deficiencies included not creating remediation plans

for known vulnerabilities, running outdated software, neglecting to terminate user accounts when employees ceased to work for the facility, failing to isolate special-purpose system segments from the rest of the network, and not properly retaining database audit logs used to recognize and investigate an attack. As these controls are designed to protect systems, they must be promptly fixed to prevent unauthorized access to critical network resources and loss of personally identifiable information, or impede effective responses to incidents. The OIG made five recommendations to mitigate these risks.

# Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections and reviews prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports in September.

## Management Advisory Memorandum

### Facility Leaders and Staff Have Concerns About VA's New EHR

The OIG conducted healthcare facility inspections of the VA Southern Oregon Healthcare System in March 2024 and the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington, in June 2024. During the inspections, leaders and staff at both facilities described notable concerns with the new EHR system related to efficiency and loss of productivity, staffing, financial impacts, and patient safety. Since 2020, the OIG has reported on various issues with the new EHR. The comments made by these leaders and staff demonstrate that new and previously identified issues persist. The OIG issued this management advisory memorandum to inform the VA under secretary for health of these concerns and to request that he evaluate whether the issues cited in the memorandum warrant process reviews or contract enhancements to improve efficiency, user experiences, and patient safety.

## Healthcare Inspections

### Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama

This OIG inspection evaluated the care provided by VA Tuscaloosa Healthcare System staff to a patient who died by suicide and yielded the following findings:

- A mental health nurse practitioner failed to inform the patient of mirtazapine-related suicide risk, to complete required suicide screening, and to closely monitor the patient.

- Administrative staff did not schedule a follow-up appointment in a timely manner.
- A social worker, who received inadequate supervision, neglected to sufficiently assess suicide risk, conduct lethal means safety counseling, and seek consultation.
- Facility staff did not arrange the patient's posttraumatic stress disorder treatment or submit a traumatic brain injury evaluation consult.
- A suicide prevention coordinator failed to complete Behavioral Health Autopsy Program (BHAP) documentation; and
- VHA leaders did not provide guidance to suicide prevention staff on when not to contact family for a BHAP interview.

The OIG made one recommendation to the under secretary for health and 13 recommendations to the facility director for corrective action.

### Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at the VA Western New York Healthcare System in Buffalo

The inspection team found that scheduling delays by this healthcare system's community care staff for radiation therapy and neurosurgery appointments in the community resulted in delayed patient care and, at times, patient harm. For one patient, a scheduling delay for a community care radiation therapy appointment (which was eventually cancelled) for cancer-related pain resulted in progressive, debilitative pain, affecting the quality of life during the patient's final months. Leaders did not conduct an institutional disclosure. Despite staff's advocacy efforts, healthcare system and community care leaders failed to resolve scheduling delays for patients with serious health conditions. Leaders relied on inaccurate assurances from community care leaders that urgent, high-risk patient care consults were reviewed and prioritized. The OIG made two recommendations to the VISN director related to system leaders' responses to patient concerns and oversight of community care practices, as well as two recommendations to the healthcare system director related to the establishment of community care policies in alignment with VHA community care standards, and the disclosure of an adverse event.

## Mental Health Inspection

### Mental Health Inspection of the VA Augusta Health Care System in Georgia

An OIG team conducted a mental health inspection of the acute inpatient setting at the VA Augusta Healthcare System. The focus was on leadership and organizational culture, high reliability principles, recovery-oriented principles, clinical care coordination, suicide prevention activities, and safety. The team identified concerns with committee structures, oversight and monitoring, and staffing practices. The inpatient unit also had some design elements that did not

meet VHA standards for a safe, hopeful, and healing environment. In addition, the OIG found communication gaps and inconsistent information shared among leaders regarding low census (fewer patients than the facility's staff can serve) and the extent to which community care was being used. Staff did not comply with requirements for documentation of medication discussions, safety plans, and discharge summaries and instructions. The OIG also found noncompliance with suicide risk screening and evaluation, ongoing assessment of suicide hazards, and completion of mandatory staff trainings on suicide prevention and environment of care. The report includes 21 recommendations designed to improve the quality and delivery of veteran-centered, recovery-oriented care in the inpatient mental health unit and beyond.

## Healthcare Facility Inspections

The Healthcare Facility Inspections (HFI) Program reviews VHA medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff. August's HFI reports examined the following facilities:

- VA Orlando Healthcare System in Florida
- VA Hudson Valley Healthcare System in Montrose, New York

## Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families. The OIG selects and evaluates specific areas of focus on a rotating basis for its vet center inspections. See the report overview section of each report for the focus areas at the time of the inspection. September's VCIP reports focused on the following districts and vet centers:

- Pacific District 5 Zone 1: Vet Centers in Anchorage, Alaska; Eugene, Oregon; and Everett and Walla Walla, Washington
- Pacific District 5 Zone 2: Vet Centers in Corona and Temecula, California, and Kauai and Western Oahu, Hawaii
- Pacific District 5 Zone 3: Vet Centers in Phoenix and West Valley, Arizona; Antelope Valley, California; and Santa Fe, New Mexico

# Featured Hotline Cases

The OIG's hotline staff accepts complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross mismanagement of VA programs and operations. The following two cases opened by the Hotline Division were not included in the inspections, audits, investigations, or reviews detailed above.

### VA Medical Center in Tucson, Arizona, Failed to Follow National Guidance for Continuous Glucose Monitoring

A complainant alleged that the Tucson VA Medical Center was not following national guidance for continuous glucose monitoring (CGM). CGM assists diabetic patients in managing their blood glucose levels using a wearable device. The matter was referred to and reviewed by VISN 22, which substantiated the allegation. The VISN's fact-finding team conducted interviews with medical center leaders and staff in primary care, pharmacy, and endocrinology. They also reviewed the facility's patient advocate cases associated with CGM. Following its review, the VISN oversaw corrective actions at the medical center, including forming a workgroup to adjudicate CGM prescription and patient safety; developing a plan for making CGM available for veterans who meet VHA guidance criteria; and training staff to help expand and manage the program.

### Obsolete and Damaged Hemodialysis Equipment Caused Patient Safety Concerns at the San Juan Va Medical Center in Puerto Rico

The medical center conducted a review after receiving an OIG hotline referral, which substantiated allegations of damaged and obsolete equipment in the hemodialysis unit. Specifically, 48 of 61 pieces of assigned property were past their predetermined equipment "duration expectancy"—similar to an expiration date. The medical center review team also found all 14 beds in the hemodialysis unit were within a year of their replacement dates, including one that was not in service and pending repair and six that were missing key functionalities. Of particular concern, the improper functionality of one bed was found to be a contributing factor in three employee injuries. The medical center has since taken that bed out of service and replaced a total of six beds through existing hospital stock. However, the medical center review team recommended that all 14 beds be replaced early.

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To listen to the podcast on the September 2024 highlights, go to the monthly highlights page on our website.