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OFFICE OF INSPECTOR GENERAL

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Fiscal Year 2024 Inspector General's Report on VA's Major Management and Performance Challenges

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Foreword

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, survivors, and the public by conducting effective independent oversight of VA programs, operations, and services. Each year, the Inspector General summarizes the top management and performance challenges identified by OIG work and assesses 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 have been identified by OIG personnel, with assistance from external oversight agencies and organizations, VA leaders, 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.

The OIG recognizes the monumental challenges VA faces. VA is implementing a number of new systems critical to safely and promptly meeting the needs of veterans, while making the best use of taxpayer dollars. This includes attempting to continue the deployment of VA's multibillion dollar electronic health record system, while also fielding a new financial management system intended to improve how the department handles taxpayer funds.

The implementation of the historic passage of the PACT Act has resulted in millions more veterans applying for related benefits and health care, even as VA struggles to manage the impacts of increased numbers of veterans seeking eligible care within their communities. Several OIG reports illustrate VA's continued inability to hold third-party providers to contract requirements, and a lack of private-sector providers has left some veterans without the critical care they need.

Despite a hiring "surge," VA still suffers from critical staffing shortages. Other challenges such as ensuring patient safety, maintaining timely access to quality health care, and addressing deficiencies that center around failures in VA governance and accountability are just some of the major management challenges that OIG reports have identified.

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

Michael J. Missal
Inspector General

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OIG Challenge #1: Healthcare Services

A series of legislative changes have allowed VA to outsource more healthcare services for veterans to private-sector community providers. According to internal VA data, between FYs 2021 and 2023, referrals to community care have increased over 37 percent, with FY 2024 (as of May) outpacing FY 2023 by more than 16 percent.

As veterans obtain more services from the community care program, VHA has struggled to oversee the performance of their third-party administrators—the contracted entities that manage the network of community providers—and ensure they meet their contractual requirements. Recent VA OIG reports have found that VA medical facilities have failed at times to get these administrators to make certain that local area providers are accessible to eligible veterans who seek or require care outside the facility.

Apart from community care, the VA OIG has also found that staffing shortages at VA medical facilities have not only degraded veterans' access to care—particularly mental health care—but also the quality of care provided. In the VA OIG's most recent occupational staffing report, VHA facilities self-reported for FY 2024 a total of 2,959 severe occupational staffing shortages. Eighty-six percent of facilities reported severe occupational staffing shortages for medical officers, and 82 percent of facilities reported severe shortages for nurses. Psychology was the most frequently reported severe clinical occupational staffing shortage, and this shortage is particularly meaningful in the delivery of mental health care.

However, while new demands and challenges increase the urgency for VA to address long-standing staffing shortages, it must balance the need to conduct proper background investigations with the quick onboarding of staff. Having the right people in the right positions committed to doing the right thing is essential to building and maintaining a culture of accountability. The OIG has published reports on deficiencies in the personnel suitability program since 2017. Recent oversight reports have continued to identify such problems. One report identified weaknesses in governing background checks for contracted employees, which increases the risks to the health and well-being of veterans and VA employees, as well as the efficiency and integrity of VA services.

Why This Is a Challenge

Coordinating medical care between the VHA healthcare system, third-party administrators, and private-sector community providers continues to be a challenge, especially as the demand for community care continues to grow. In recent reports, the OIG found third-party administrators generally used providers from their existing healthcare portfolios to build VHA's provider networks without verifying the providers' contact information or whether the providers would accept VA patients. The lack of verification by the third-party administrators left inaccuracies in VHA's master database of community care providers. The Office of Integrated Veteran Care—

the VHA office responsible for overseeing access to care in the community—is required by VHA directive to ensure provider availability and that third-party administrators meet contract requirements. OIG reporting found they failed to do both; therefore, facilities were left without enough providers and veterans were not receiving timely care in the community. Finally, because the Office of Integrated Veteran Care did not have a process in place to analyze provider network adequacy, they couldn't help the facilities justify the need to add more third-party administrators.

Other recent OIG work highlighted coordination failures between VHA, the third-party administrators, and community providers. Specifically, community providers rarely submitted initial prescriptions for special-authorization drugs with required justifications and VHA did not hold the administrators accountable for making certain that community providers followed formulary procedures for special-authorization drugs. This occurred partly because the electronic prescription system lacked the means to include justifications.

With respect to staffing, in the past year, VHA leaders have reported that shortages led to closure of medical surgical beds, as well as the inability to process sterilization of medical instruments, leading to more than 1,500 procedures being canceled, rescheduled, or referred to the community. Some VHA officials expressed concerns about the inability to maximize community living center bed capacity due to the length of time it takes to onboard new staff, and others expressed that the difficulties with hiring could put medical centers at risk for additional staffing shortages.

Department's Corrective Actions

As part of VA's efforts to ensure VA medical facilities have enough community care providers to provide timely care for veterans, the Office of Integrated Veteran Care launched the Advanced Medical Cost Management Solution suite in October 2022, which allows users to assess the adequacy of community providers networks by locality. VHA will need to leverage its Advanced Medical Cost Management Solution suite to conduct routine assessment of facility-level network adequacy and provide training for relevant facility staff. In addition, VHA needs to hold future third-party administrators accountable for operational readiness and provider network adequacy, as well as develop processes to update and maintain community care network data.

To improve community provider compliance with VHA's standards for special-authorization prescriptions, VHA should add electronic system capabilities allowing users to attach medical justifications. The Office of Integrated Veteran Care should also train community providers on the VA formulary process.

Finally, to better meet its hiring goals, VHA needs to coordinate and clearly define roles and responsibilities at each organizational level. It also needs to ensure regional and facility staff monitor progress and address challenges in filling positions. VA removed some of the conflicting guidance from its website and is working to update existing personnel suitability policy. VA needs to develop a plan to ensure that future systems support the functionality needed to

effectively oversee and manage the background investigation process, including addressing limitations identified in the current system.

OIG Challenge #2: Benefits for Veterans

VBA processes millions of claims that provide veterans, eligible family members, and caregivers a wide array of benefits, including disability compensation, pension benefits, education, and vocational training. VBA must balance the need to accurately process complicated claims and benefit requests while still meeting challenging deadlines. In addition, it must protect VA beneficiaries who are unable to manage their VA benefits due to injury, disease, or age.

VBA's responsibilities have increased significantly with the passage of The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, which expands VA health care and benefits for veterans exposed to burn pits and other toxic substances. The PACT Act is perhaps the largest healthcare and benefit expansion in VA history. According to VA, as of July 14, 2024, more than 325,000 veterans presumed to have toxic exposure during military service for the purposes of benefit payment consideration have newly enrolled in VA health care since the act's passage in 2022. Further, more than 5.5 million veterans have completed toxic exposure screenings and over 1 million claims have been approved. In addition to VBA's other claims backlog, the PACT Act benefit claims backlog was around 390,000 in June 2024. To address the swell in workload demands, VA has expanded hiring to fill thousands of healthcare and benefits personnel positions.

In a July 2024 congressional testimony, the OIG highlighted persistent concerns with VBA quality assurance and training—identifying oversight reports that document continued issues with (1) processing errors VBA personnel made on veterans' individual unemployability claims, (2) inconsistencies implementing changes to the disability rating schedule, (3) issues with claims automation, and (4) unwarranted medical reexaminations for veterans.

Why This Is a Challenge

VBA processes claims that can be extremely complex, especially when the agency must interpret VA policies and guidance that may be unclear. When regulations add new presumptive diseases of service connection, VA must search its records to find eligible claimants and award benefits. A recent report found VBA failed to identify and notify veterans who were potentially eligible for prior disability claim readjudication and retroactive benefits under the National Defense Authorization Act. A VA senior management advisor stated VHA records were not involved in these readjudication determinations because they were part of a VHA data set, and not part of VBA's records. Because VBA did not send these veterans notification letters, some 87,000 veterans or their survivors were not made aware of their potential entitlement to retroactive compensation benefits. The OIG believes VHA's records were available and should have been included in the initial readjudication determinations.

Other OIG oversight reports on VA's compensation and pension programs have found that overpayments, underpayments, or other improper payments (such as those that lack support or documentation) are often caused by a lack of effective internal controls and inadequate technology.

For example, when veterans request a waiver to participate in vocational training that is not covered under their GI Bill benefits, VBA's weak internal controls resulted in improper authorizations because Veteran Readiness and Employment staff misinterpreted the application of the applicable law. The basic case of this issue was that VBA staff were not trained on how certain programs could be used by veteran program participants. Veteran Readiness and Employment controls also did not prevent participants from being authorized and enrolled in unapproved courses.

In another example, VBA established the Fiduciary Program to protect VA beneficiaries who are unable to competently manage their own VA benefits. Questionnaires are used to help medical professionals assess a veterans' mental competency for managing their benefits, but a recent report discovered inconsistencies in these questionnaires, which can lead to inconsistent medical assessments. Such inconsistencies can lead to discrepancies in how rating veterans service representatives assess a veteran's mental competency—a matter of the greatest importance.

Other oversight reports have found weaknesses in the Fiduciary Program governance. The reports identified delays in determining whether a fiduciary is warranted, in reimbursing veterans when their benefits have been misused by a fiduciary, and in distributing of deceased veterans' fiduciary-controlled funds to their heirs. The delays often created—at difficult life moments when VA's assistance was critical—unnecessary risks to veterans' welfare and exposed beneficiaries and their families to potential hardships.

Department's Corrective Actions

The OIG acknowledges that VBA personnel face significant difficulties in processing often complex claims. These challenges are exacerbated by constantly changing policies and processes, increasing workloads, as well as tight timelines. This state of constant change reinforces the OIG's calls for VBA to provide its employees with accurate, timely, and effective training.

The OIG also acknowledges that VBA has improved its quality assurance review process by implementing action plans associated with OIG report recommendations. VBA officials have initiated plans to establish a work group to better identify veterans potentially eligible for prior disability claim readjudication. To improve mental competency determinations, VBA updated the post-traumatic stress disorder questionnaire in August 2023 to include VA's regulatory definition in the initial questionnaire.

However, one of the critical foundations of accountability for any program is effective quality assurance to detect and resolve issues. The OIG has found that VBA needs to improve the execution of its quality assurance review program so that eligible veterans receive the disability compensation benefits they are due.

To improve compensation and pension claim accuracy, VBA needs to ensure it continuously monitors internal controls to prevent procedural, technology, or process failures that result in improper payments. This monitoring can make certain that VBA is acting as an effective steward of taxpayer funds and to protect veterans and their families from related hardships. Similarly, improper entitlement payments could be prevented if VBA develops and implements policies and system controls to verify that programs meet requirements and there is effective training for all appropriate Veteran Readiness and Employment regional office staff.

Also, VBA staff should use improved methodologies to identify eligible veterans and update the standard operating procedures accordingly to identify and notify veterans potentially eligible for prior disability claim readjudication and retroactive benefits under the National Defense Authorization Act.

OIG Challenge #3: Stewardship of Taxpayer Dollars

Congress and the media have consistently questioned VA budget requests and financial management deficiencies. In August 2024, VA reported a gap in funding for FY 2025 of approximately $12 billion, drawing increased scrutiny of the department's ability to forecast and manage its finances. VA has attributed some of the funding gap to recent surges in its workforce, unanticipated spending, and the broader scope of services to record-high numbers of veterans associated with passage of the PACT Act and other measures—the effects of which will continue to be felt for some time. These statutory measures qualify millions of additional veterans for healthcare enrollment and benefits that can affect the department's capacity to provide quality and timely care and services.

VA continues to face significant challenges concerning how it oversees its spending. Many OIG reports have shown instances of inadequate oversight and weak internal controls over community care spending, inventory management, purchase card usage, contract management, and open obligations. These issues have been compounded by VA's outdated financial management system and outdated or incomplete data. Although VA has started deploying iFAMS—a new financial management system intended to improve how the department handles taxpayer funds—VA continues, in many areas, to rely on legacy financial systems, manual reconciliations, and adjustments, which has caused VA to be noncompliant with major financial management regulations.

The OIG recognizes that claims processing can be tremendously complex. As stated above, the lack of internal controls—in addition to inadequate technology and unclear policies and

guidance—is the primary cause of overpayments and underpayments. Internal controls are therefore vital to quality assurance and help ensure the integrity of systems and processes. Minimizing improper payments will also require strong leadership, effective supervision, clear procedures, and adequate staff training. Many of the weaknesses identified in OIG oversight reports have also been the result of poor planning and implementation of information technology that is meant to support the work of VBA personnel. The OIG recognizes that VBA staff face these and other challenges daily to keep pace with tremendous workloads while attempting to ensure eligible beneficiaries are given the compensation and pensions they are due while preventing waste.

VA also continues to experience issues in monitoring community care program claims and payments, which impacts their ability to detect duplicate claims and payments across different claims processing systems as well as in seeking reimbursement from third-party insurance companies for services rendered to veterans who are ineligible for VA payment. This is due to the Program Integrity Tool database being offline as of February 2023 following the discovery of various data integrity and quality issues in the database. In addition to being the source of comprehensive community care data from multiple source systems, the tool was also, the tool was also the sole source of Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) data as well as historical community care program data (e.g., Veterans Choice Program, Patient-Centered Community Care or PC3).

Finally, benefit payments paid by VBA to deceased veterans and beneficiaries increased from $4.2 billion in 2019 to $7.6 billion in 2023. These payments included various benefit awards, such as pensions, disability compensation, and educational benefits. When VBA's death match process fails to accurately identify deceased veterans and beneficiaries, these payments can continue erroneously, placing unnecessary financial and emotional burden on surviving family members, creating additional workload for VBA personnel to rectify these errors, and resulting in improper use of taxpayer funds.

Why This Is a Challenge

From FY 2022 to FY 2023, community care expenditures grew by 22 percent, from $25.9 billion to $31.6 billion. Given the size of the program, it is critical that VA pay only for authorized care. A recent OIG report found, however, that VA has paid for unauthorized dental care through the community care program. For community care network invoices, the contracted third-party administrators' adjudication systems process did not identify unauthorized procedures because community care network contract language contradicted VHA referral guidance for community dental claims.

Also, the OIG has repeatedly found that, when VA acquires day-to-day medical goods, it does not always use the required strategically sourced contracts that can help VA save taxpayer funds. For example, VHA requires its medical facilities to use the Medical/Surgical Prime Vendor

program's distribution contracts for cost-effective ordering and distribution of day-to-day healthcare supplies. However, medical facilities did not always purchase through the program because items were often unavailable, and staff often did not check the program before ordering from the open market. Additionally, the OIG found that VHA did not ensure dialysis services were purchased through the community care network contracts; instead, dialysis was purchased through nationwide dialysis services contracts, which charged higher per treatment rates.

Unreliable data has frequently prevented the department from making informed decisions on how to best manage program and medical funds. Several reports have identified discrepancies between what was reported in medical facilities' inventory systems and what was physically present. Errors could diminish the healthcare system's ability to effectively budget for the purchase of supplies to meet patient care needs.

Department's Corrective Actions

VHA needs to strengthen its prepayment and postpayment review processes for community care authorizations. To facilitate the use of strategically sourced contracts, VHA needs to improve staff training and clarify contract usage guidance. Additionally, to improve facility inventory management, VHA needs to ensure inventory values are recorded correctly in its inventory system and establish processes and procedures for monitoring inventory reports.

To improve the usage and increase transparency of the Medical/Surgical Prime Vendor program, VHA plans to simplify the system to better enable facilities to use the required contracts for day-to-day medical expenses.

VBA's internal controls should be continuously monitored to prevent procedural, technology, or process failures that result in improper payments—not only as stewards of taxpayer funds but also to protect veterans and their families from related hardships. The problems the OIG identified with VBA's compensation and pension programs are, in many cases, the result of established and new mechanisms that are insufficient in preventing and detecting errors caused by information management systems and compliance with processes. Recognizing that VBA personnel work in a fast-paced environment on often complex processes, the OIG will continue to make recommendations for improvement that support their efforts to serve veterans, their families, and other survivors.

OIG Challenge #4: Information Systems and Innovation

VA is undertaking massive modernization efforts for systems that are estimated to cost tens of billions of dollars and are interdependent—making implementation both costly and complex.

The OIG encourages innovation and recommends enhancements to VA's infrastructure and systems through findings and recommendations that address information technology, data

security, predictive tools, and financial management systems. VA relies on countless systems to meet the needs of patients safely and promptly, to provide benefits and services to eligible recipients, and to support the strong stewardship of taxpayer dollars.

Information system failures have repeatedly contributed to breakdowns in a number of critical VA functions, including financial reporting, supply chain management, claims processing, appointment management, community care prescription requests, and personnel suitability adjudications. Weak information technology security controls can put sensitive personal information belonging to veterans at risk.

VA has long recognized the need to modernize its electronic health record information system to ensure greater interoperability with the Department of Defense and exchange information with community care providers, yet it has struggled to deploy the multiyear effort initially estimated to cost $16 billion. In several reports, the OIG has identified a variety of barriers to implementation, including patient harm and safety concerns; pharmacy and medication management issues; inadequate cost estimates; an unreliable implementation schedule; difficulties with the patient appointment scheduling system; and reporting, training, and decision-making deficiencies. The failures have been a tremendous burden on healthcare providers where the system has been deployed and it has potentially contributed to veterans' deaths and poor outcomes because of delays, inaccuracies, and poor functionality.

Furthermore, the OIG has 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. It also makes it difficult for VA staff to plan, order, and track expenditures for supplies and services, and hampers oversight of VA's use of these funds. Limited functionality contributed, for example, to obstacles in ensuring COVID-19 supplemental funds were properly spent.

After failed attempts to replace its systems in 2004 and 2010, VA established a program to oversee the multiyear deployment of its new iFAMS, an enterprise-wide modernization to replace legacy systems that facilitated the department's financial and contracting activities. As of June 2024, this system has been deployed at several offices across VA; however, VHA, which represents the most significant user base, had yet to start using the system. The OIG has reported issues with the new system's first deployment at the National Cemetery Administration and end-user concerns with training. In FY 2025, VA expects to roll out the new system for VBA's loan guaranty program. However, the life-cycle costs for iFAMS have grown to over $7 billion.

Why This Is a Challenge

VA has historically struggled to effectively deploy new information technology projects. These efforts have often been hampered by poor planning, shifting leadership priorities, and unclear communication. While VA paused nationwide deployment of the electronic health record system in 2022 due to a troubled initial rollout, an exception to that pause was the electronic health

record deployment at the Captain James A. Lovell Federal Health Care Center, a joint facility shared between VA and the Department of Defense, in March 2024. Nevertheless, a recent OIG report identified shortcomings in the appointment scheduling package of the new electronic health record that can affect veteran engagement and appointment wait times. These shortcomings included a displaced appointment queue that could result in missed appointments not being rescheduled and cause difficulty for providers and schedulers seeking to share information. At this point, the VA has yet to make public its plan or schedule to emerge from the reset.

Poor planning has also affected successful deployment of the acquisition module of iFAMS. Leaders did not adequately include acquisition stakeholders in decision-making roles to ensure the new acquisition model addressed concerns related to functionality, lack of automation, and length of time the system took to perform various functions. In addition, users had concerns with the training provided for some tasks and day-to-day activities, leaving VA with opportunities to enhance the training program. Addressing training weaknesses now is important because over 100,000 employees have yet to be trained on the system.

Department's Corrective Actions

From April 2020 through August 2024, the OIG has published 19 oversight reports and issued 83 recommendations for corrective action focused on varied aspects of VA's electronic health record modernization program. Each oversight report is meant to help VA improve the new system's implementation and support prompt, quality health care for veterans. Failure to satisfactorily complete the corrective actions associated with these recommendations can increase risks to patient safety and the ability to provide high-caliber care at the new electronic health record sites. Fully addressing oversight recommendations can also help minimize considerable cost escalations and delays in potential future deployments.

As VA moves to implement the new electronic health record at other facilities, it will need to consider assessing staffing levels and overtime usage prior to deployment. It will also need to prepare staff with approved workflow best practices that may help to reduce employee resistance and facilitate successful adoption of the system.

VA has made progress toward implementing iFAMS, with VA's Financial Management Business Transformation Service leading and managing the implementation of the systems in 10 "waves" across VA until full implementation is achieved in 2029. As of December 2023, five waves have "gone live" across VA. VA has indicated it will use the information weaknesses OIG identified within its iFAMS training and adjust its future training before additional iFAMS deployments.

OIG Challenge #5: Leadership and Governance

The OIG's work has demonstrated a persistence of failings in VA leadership and governance that contribute to identified problems. Errors, lapses, and missteps are often attributed to the lack of clear roles and responsibilities among department officials and personnel that impedes VA's internal monitoring of the quality, efficiency, and effectiveness of its efforts.

Safe, quality health care is jeopardized when leaders and staff fail to execute their responsibilities. Inconsistent and ambiguous policies create role confusion and hinder staff's ability to perform effectively. Recent OIG reports highlight unacceptable oversight practices related to a variety of reasons, most notably staffing shortages and inconsistent or ambiguous policies. The impacts of these failures range from delays in identifying and responding to unprofessional conduct to delays in, or barriers to, coordinating patient care.

VA has struggled to consistently implement and oversee programs when multiple VA leaders across the department share responsibility. In addition, VA continues to fall short when overseeing contractors and holding them accountable.

Last year, officials at multiple levels across VA failed to ensure the requirements and intent of the PACT Act were satisfied when VA awarded about $10.8 million in critical skill incentives to 182 senior executives in the VA Central Office. The incentives were authorized by the PACT Act as a new tool for VA to use to improve recruiting and retention in anticipation of a substantial increase in healthcare enrollments and benefits claims from individuals exposed to toxic substances, which would require significant additional staffing to handle the workload. The incentives are available to an employee who "possesses a high-demand skill or skill that is at a shortage." Nearly all eligible senior executives in VHA and VBA at the central office were awarded the incentive pay for critical skill retention, with VHA providing only the most cursory justification and neither administration conducting an objective assessment of what was needed, if anything, to retain them. The senior executives were awarded the maximum percentage allowed under the PACT Act, which is 25 percent of their basic pay—resulting in awards that ranged from nearly $39,000 to over $100,000. Concerns expressed by some VA officials were not escalated to the Secretary, and some key leaders who were positioned to understand the reputational and financial risks to the department were not included in the incentive vetting process or were not provided all the facts needed to make an informed decision.

Why This Is a Challenge

Leadership and cultural development are essential for maintaining a safe, quality healthcare environment. Through strong leadership and a high-reliability organizational culture, leaders can identify, resolve, and prevent risks to patient safety. When leaders fail to establish a culture that proactively manages actual and potential risk, mistakes happen and keep happening.

Several OIG reports highlight the ongoing challenges leaders face in demonstrating leadership and cultural development and advancement. Failures to plan for low volume and high-risk complex care and activities; review and remediate personnel dysfunction in patient care areas; and comply with medical staff privileging processes represent a few vulnerabilities that have negatively affected patients, disrupted operations, and stifled efforts to ensure VA delivers the best care anywhere. Some OIG reports have identified ineffective communication systems, which do not ensure the exchange of critical patient safety information between leaders and staff, contributing to an incomplete understanding of problems and advancing a cycle of continued risks.

The VA OIG routinely reviews and publicly reports on the quality of health care VHA provides, as well as any risks to patient safety, across the nation. In many of these reviews, lack of oversight by VISN leaders and staff is a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has increased its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care. Through this effort, the OIG has repeatedly discovered inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high-reliability organization.

VHA is this country's largest integrated healthcare system, and the volume and complexity of patient encounters require deliberate and clear lines of communication and information sharing. Dotted reporting lines, optional participation in sharing critical metrics, and confusion over authority undermine the essential functions of medical facilities and further highlight the failure of the current VISN structure to ensure consistent delivery of safe care to patients.

Department's Corrective Actions

The OIG has repeatedly published healthcare reports that find there are effective and comprehensive VHA policies and skilled and dedicated staff aggressively working to carry them out to provide high-quality and timely care to veterans. Yet, OIG oversight teams also continue to find the inconsistent application or misinterpretation of policy, insufficient VA personnel training, and other issues that could be mitigated by a clear and consistent structure of authority and accountability. Such a structure would clarify roles and responsibilities for those who could track and identify trends in noncompliance in real time and intervene proactively.

VHA care has evolved and expanded dramatically since the creation of the VISN structure. The size of VHA, the increasing demands of meeting complex healthcare needs, the escalating cost of health care, and the simultaneous implementation of massive initiatives—such as community care, the PACT Act, and electronic healthcare record modernization—require a standardized internal oversight structure that can assume accountability for the efficient and effective implementation of these high-cost but necessary efforts. The OIG strongly encourages VA leaders at every level to use oversight reports as risk assessment tools to proactively address identified vulnerabilities in their own offices, networks, and facilities. The findings should also

stimulate discussions about the VISN structure and its role in ensuring and supporting consistent high-quality care to veterans.

Lastly, to avoid another costly loss of public confidence, VA should revise its critical skill incentives policy to be responsive to the findings in the OIG's published report, undertake two reviews of other awarded critical skill incentives (senior field executives and nonexecutive high-demand skill incentives) to ensure compliance with the statute and policy, and examine and address the potential conflict of interest issues identified in the report. The OIG made additional specific recommendations that VA should avoid such a catastrophic lapse in senior leadership judgement and oversight in the future.

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 2024 Major Management Challenges. All VA OIG reports are available at vaoig.gov.

		Challenge				
Related Reports	**Date**	**#1**	**#2**	**#3**	**#4**	**#5**
A Hiring Initiative to Expand Substance Use Disorder Treatment Needed Stronger Coordination, Planning, and Oversight	9/4/2024	X				X
Deficiencies in Facility Leaders' Summary Suspension of a Provider and Patient Safety Reporting Concerns at the VA Black Hills Health Care System in Fort Meade, South Dakota	8/29/2024					X
VBA Needs to Improve Oversight of the Digital GI Bill Platform	8/28/2024		X	X	X	
Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida	8/28/2024	X				X
Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times	8/15/2024	X				X
Unauthorized Community Care Dental Procedures Risked Improper Payments	8/8/2024	X	X			

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024	8/7/2024	X				
Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas	7/31/2024	X				X
Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10	7/31/2024	X				X
Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming	7/25/2024	X				X
Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia	7/23/2024	X				X
The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations	7/16/2024	X				
Lessons Learned for Improving the Integrated Financial and Acquisition Management System's Acquisition Module Deployment	7/10/2024				X	X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits	6/27/2024		X	X		
Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora	6/24/2024	X				X
Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety	6/24/2024					X
Potential Weaknesses Identified in the VISN 20 Personnel Suitability Program	6/20/2024					X
Ineffective Use and Oversight of Medical/Surgical Prime Vendor Program Led to Increased Spending	6/11/2024	X		X		
VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives	5/9/2024					X
Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance	4/9/2024	X				X
Scheduling Challenges Within the New Electronic Health Record May Affect Future Sites	3/21/2024	X			X	

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus	3/21/2024	X			X	
Inadequacies in Patient Safety Reporting Processes and Alleged Deficient Quality of Care Prior to a Patient's Foot Amputation at the Edward Hines, Jr. VA Hospital in Hines, Illinois	3/20/2024	X				
Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas	2/15/2024	X				
Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk	2/8/2024					X
Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena	2/6/2024	X				X
Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Medical Center in Oklahoma	2/1/2024	X				
VA's Allocation of Initial PACT Act Funding for the Toxic Exposures Fund	1/11/2024			X		

Related Reports	Date	Challenge #1	#2	#3	#4	#5
Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures	1/4/2024					X
Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA	1/4/2024		X	X		
Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal	1/4/2024	X				
Care in the Community Summary Report for Fiscal Year 2022	11/29/2023	X				
Improvements Needed for VBA's Claims Automation Project	9/25/2023		X			
Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions	9/7/2023		X	X		

Congressional Testimony	Date	Challenge #1	#2	#3	#4	#5
"Is The Veterans Benefits Administration Properly Processing and Deciding Veterans' Claims?"	7/23/2024		X	X		X

"The Continuity of Care: Assessing the Structure of VA's Healthcare Network"	6/26/2024	X				X
"Bonus Blunder: Examining VA's Improper Decision to Award Senior Executives Millions in Incentives"	6/4/2024			X		X
"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA"	4/10/2024	X				
"EHR Modernization Deep Dive: Can the Oracle Pharmacy Software be Made Safe and Effective?"	2/15/2024	X		X		X
"Is VA Illegally Spending Taxpayer Dollars in its Compensation and Pension Programs?"	2/14/2024		X	X		X
"Vet Centers: Supporting the Mental Health Needs of Servicemembers, Veterans, and Their Families"	1/31/2024	X				
"Background Checks: Are VA's HR Failures Risking Drug Abuse and Harm?"	12/6/23	X	X			X
"VA's Fiduciary Program: Ensuring Veterans' Benefits are Properly Managed"	9/28/2023		X	X		