JULY 2025 HIGHLIGHTS

The Honorable Cheryl L. Mason was confirmed by the Senate as the inspector general of the Department of Veterans Affairs on July 31, 2025. She was sworn in on August 4 and began work at the OIG the same day. IG Mason previously served as the chairman of the Board of Veterans' Appeals at VA. She is the spouse of a retired US Air Force lieutenant colonel and daughter of a World War II US Navy veteran. For more information on IG Mason, see her bio.

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. All written statements to Congress can be found on the OIG website.

Audit Director Testified on OIG Findings About VA's Incentive Payment Programs

Shawn Steele, director of the human capital and operations division for the Office of Audits and Evaluations, testified on July 22 at a hearing before the Subcommittee on Oversight and Investigations of the House Veterans' Affairs Committee (HVAC). His testimony focused on the OIG's findings in a recent report on deficiencies in VA's recruitment, retention, and relocation incentive payments. The OIG's long-standing oversight work has highlighted VHA's ongoing challenges with addressing severe occupational shortages in essential clinical and nonclinical positions. Mr. Steele noted that, in an attempt to narrow these staffing gaps through recruitment, relocation, or retention incentives, VHA must consistently follow VA requirements. His statement discussed how identified problems were not routinely detected by VA's quality control measures. In response to questions, Mr. Steele explained that these issues persist because of weaknesses in VA's human resources information technology systems and failures by responsible employees to ensure required documentation is completed and recorded. In addition to the written statement on the OIG website, the hearing can be viewed on the House Committee on Veterans' Affairs website.

OIG Issued Statement for the Record on Veteran Readiness and Employment Program

The OIG provided a statement for the record for the HVAC's Subcommittee on Economic Opportunity hearing titled, *Path of Purpose: Restoring the VA VR&E Program to Effectively Serve Veterans* (July 16). The statement highlighted two OIG reports that identified concerns with internal controls and oversight challenges. The first report, *Staff Did Not Limit the Use of Schools and Training Programs That Were Only Approved for the Veteran Readiness and Employment Program,* found VBA did not implement a law to approve and monitor veterans' use of Veteran Readiness and Employment Service–only (VR&E) programs, which may only be

tapped when GI Bill programs are insufficient. The second report, *Veteran Readiness and Employment Staff Improperly Sent Participants to Veteran Employment Through Technology Education Courses*, found that VR&E participants were being improperly authorized for the Veteran Employment Through Technology Education Courses program, which provided veterans with the opportunity to pursue high-technology training outside the regular VR&E program. Furthermore, the statement discussed the OIG's investigative efforts to combat fraud in the VR&E program. It also described how the OIG's oversight efforts have helped VBA address significant internal control deficiencies and monitoring challenges, as well as fraudulent activities that drain resources from programs meant for veterans' employment assistance.

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 July.

Healthcare Investigations

Eleven Members of a Transnational Criminal Organization Indicted in Multibillion-Dollar Healthcare Fraud and Money Laundering Scheme

A multiagency investigation resulted in charges alleging that 11 members of a transnational criminal organization submitted billions in fraudulent claims to federal and private health insurance programs—including the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Medicare—for durable medical equipment that was never prescribed or issued to the beneficiaries. This resulted in payments of about $900 million from Medicare supplemental insurers. Of this amount, about $1.8 million is estimated to have been paid through CHAMPVA. The defendants were indicted in the Eastern District of New York on charges of money laundering and healthcare fraud as part of the Department of Justice's National Healthcare Fraud Takedown. This investigation was conducted by the VA OIG, Department of Health and Human Services OIG, Office of Personnel Management OIG, and FBI.

Former Inventory Management Specialist at the Cleveland VA Medical Center and Coconspirator Indicted for Purchase Card Theft Scheme

This multiagency investigation resulted in charges alleging that a former inventory management specialist at the Cleveland VA Medical Center misused his VA-issued purchase card by procuring electronics and other items for his personal use. He allegedly sold some of the stolen property to a coconspirator, who then transported the items out of state for resale. The former

VA employee and the coconspirator were indicted in the Northern District of Ohio on charges of theft of government property and interstate transportation of stolen goods. The total loss to VA is approximately $198,000. This investigation was conducted by the VA OIG, Lake County (Indiana) Sheriff's Office, and VA Police Service.

Former Home Health Aide Sentenced for Theft Scheme

A VA OIG and Branford (Connecticut) Police Department investigation revealed a former home health aide worker gained access to the bank account of a veteran to whom he was providing care and stole approximately $37,000 for his personal use. In addition to cash withdrawals, the fraudulent purchases included designer clothing, rare sneakers, hotel rooms, and alcohol. The aide was sentenced in New Haven Superior Court to 60 months' imprisonment after pleading no contest to charges of larceny, telephone fraud, and illegal furnishing of money, goods, or services on a payment card.

Former VA Subcontractor's Employee Sentenced for Illegally Accessing a Veteran's Medical Record

A VA OIG and FBI investigation revealed that a former employee of a VA subcontractor accessed a veteran's VA medical records without a legitimate business need. The former employee also made a false statement to VA OIG and FBI agents about the type of individually identifying health information he used to access the veteran's VA medical records. He was sentenced in the District of Nebraska to 24 months' probation after previously pleading guilty to the wrongful disclosure of individually identifiable health information under the Health Insurance Portability and Accountability Act (HIPAA).

Benefits Investigations

Six Charged in Conspiracy to Defraud Veterans and VA of Nearly $20 Million in GI Bill Benefits

Another VA OIG investigation resulted in charges alleging that four owners and one certifying official for multiple for-profit, non-college-degree schools that purported to provide courses in cybersecurity and computer coding hired a conspirator who targeted and recruited veteran students to attend their schools. VA regulations prohibit schools from compensating individuals who recruit and enroll veteran students with a portion of the tuition that they secure. The defendants allegedly paid the conspirator approximately 25 percent of the Post-9/11 GI Bill benefits the schools obtained through the veteran students he enrolled. The defendants also undertook various efforts to conceal and obscure the nature of this recruitment from VA auditors, including by using coded terms, hidden payments, backdated and falsified contracts, and phony enrollment records. Some of the schools also created false records of attendance of nonveteran students to legitimize and disguise the dramatic increases of veteran enrollments. Allegedly, only

a small fraction of the veteran students sought or obtained any certifications in programs purportedly taught by these schools. The five defendants were indicted in the Middle District of Florida on charges of conspiracy to commit wire fraud and wire fraud. The conspirator was charged by criminal information (a formal charging document prepared by a prosecutor that describes the criminal charges against a defendant and the factual basis for those charges) and signed a plea agreement in which he agreed to forfeit more than $3.9 million as an estimate of the amount he personally obtained from the scheme. The loss to VA is approximately $19.2 million.

Family Members of Veteran Pleaded Guilty in Connection with Caregiving Services Fraud Scheme

A VA OIG proactive investigation resulted in charges alleging that between July 2012 and October 2024, a veteran fraudulently obtained disability compensation benefits by falsely representing to VA that she was unable to walk or use her right arm and required assistance with performing activities of daily living. The charges also allege that the veteran and her sister and son conspired to fraudulently obtain caregiving services from VA's Veteran Directed Care program. The total loss to VA is more than $1.1 million. The veteran's sister pleaded guilty in the Western District of Washington to conspiracy to commit theft of government property and healthcare fraud. The veteran's son also pleaded guilty to theft of government property and healthcare fraud. The veteran has been indicted and is awaiting trial.

Veteran Pleaded Guilty to VA Disability Compensation Benefits Fraud

After medically retiring from the Army in 1983 due to an eye condition, a veteran received VA disability compensation benefits with a 100 percent service-connected rating for legal blindness while maintaining a Florida driver's license. The VA OIG proactive investigation revealed the veteran misrepresented his true visual acuity during VA examinations in order to fraudulently receive 100 percent service-connected disability benefits for blindness. Despite his claims to VA, the veteran maintained a Florida driver's license (since 1993) and passed multiple associated vision examinations with the Florida Department of Motor Vehicles. By pleading guilty, the veteran acknowledged that he fraudulently led VA to believe that he was blind when he was capable of operating a motor vehicle. The loss to VA is approximately $1.1 million. The veteran pleaded guilty in the Middle District of Florida to theft of government funds.

Former Scuba Diving School Owner Pleaded Guilty to Education Benefits Fraud Scheme

Another VA OIG proactive investigation revealed the former owner of a scuba diving school defrauded VA's Post-9/11 GI Bill and Vocational Rehabilitation and Employment programs by falsely representing to VA that some of the school's VA-funded students had completed various

scuba diving courses although the students had either stopped attending the courses or never attended at all. The investigation also revealed that the former owner directed staff to falsify student attendance records, grade sheets, and certificates of completion to make it appear as if the students had attended class with the knowledge that these records would be reviewed by the state approving agency and VBA employees during VA compliance surveys. The loss to VA is more than $907,000. The former school owner pleaded guilty in the Middle District of Georgia to presenting false claims.

Veteran and Spouse Indicted in Connection with Compensation Benefits Fraud Scheme

A VA OIG and Social Security Administration OIG investigation resulted in charges alleging that a veteran and his wife provided false information to VA related to the veteran's compensation benefits and rated disabilities and the need for his wife to be his caregiver. The defendants claimed the veteran relies on a wheelchair and is unable to feed or bathe himself. However, on numerous occasions during the investigation, reports stated the veteran was observed walking unassisted, running, and performing various tasks contrary to his reported disabilities. The veteran received more than $450,000 in VA compensation benefits and his wife received more than $250,000 from the VA Caregiver Support Program. The veteran and his spouse were indicted in the Western District of New York on charges of theft of government funds, wire fraud, conspiracy to commit wire fraud, conspiracy to defraud the government, and making false statements.

Former VA Veterans Service Representative Pleaded Guilty to Federal Extortion, Bribery, and Witness Tampering Charges

A multiagency investigation revealed that a former veterans service representative at the Providence VA Regional Office solicited and accepted bribes from veterans and the family member of a veteran to approve requested disability benefits or dependent care benefits. The former employee falsely claimed to his victims that some of the money he sought from them would be used to purchase gift cards for other purported VA employees who either could or did assist him in expediting and approving benefits claims. Despite these claims, the former employee kept the money for himself. In total, he received illegal payments from three veterans and one nonveteran family member totaling more than $27,000. He pleaded guilty in the District of Rhode Island to charges of extortion, bribery, gratuity received by a public official, and witness tampering. The investigation was conducted by the VA OIG, VA Police Service, US Postal Inspection Service, Defense Criminal Investigative Service, and FBI.

Another Former VA Veterans Service Representative Pleaded Guilty to Unlawfully Receiving Gratuities

This VA OIG investigation revealed that a former veterans service representative at the Huntington VA Regional Office received illegal payments from 13 veterans totaling approximately $25,000. The scheme involved taking money from veterans in exchange for assistance in obtaining a higher service-connected disability rating, resulting in more VA monthly compensation benefits—with the employee charging the veterans approximately 10 to 20 percent of any retroactive payment they received from VA. The former Huntington employee pleaded guilty in the Southern District of West Virginia to receiving gratuities while being employed by the executive branch of the US government.

Brother of Deceased Veteran Pleaded Guilty to Theft of Government Benefits

A joint VA OIG and Social Security Administration OIG investigation revealed the brother of a deceased veteran continued to collect and withdraw VA compensation benefits and Social Security benefits intended for that veteran following his death in November 2012. The brother used the funds for his personal benefit. He pleaded guilty in the Western District of Louisiana to theft of government funds. The loss to the government is more than $289,000. Of this amount, the loss to VA is approximately $128,000.

Investigations Involving Other Matters

Former Philadelphia VA Medical Center Engineer Sentenced for Using Fictitious Company to Defraud VA

A VA OIG and FBI investigation revealed that a former engineer at the Philadelphia VA Medical Center submitted false invoices to VA on behalf of a fictitious heating, ventilation, and air conditioning company that he established with his girlfriend. Using his VA position, the former engineer identified fake work to be performed at the facility by the fictitious company. After falsely confirming that the work had been completed, he authorized an unsuspecting VA purchase card holder to pay the fictitious company. After receiving payment from VA, the girlfriend returned money to the former engineer, either by check or envelopes containing cash. In total, he defrauded VA of more than $500,000. The former engineer was sentenced in the Eastern District of Pennsylvania to 64 months' imprisonment and 36 months' supervised release, and he was ordered to pay restitution of approximately $565,000 to VA after having been previously found guilty following a jury trial on charges of wire fraud. The girlfriend was previously sentenced to three months' probation and ordered to pay restitution of more than $41,000 to VA after pleading guilty to bankruptcy fraud related to the fictitious company.

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 July.

Featured Report

Implementation of a Military Sexual Trauma Operations Center Resulted in Minimal Change Despite Planned Intent to Improve Claims-Processing Accuracy

The OIG reviewed VBA's planning and implementation of the Military Sexual Trauma Operations Center and its governance structure for processing these types of claims. The OIG found challenges with the center's hiring, retention, and recruiting. The center's turnover rate in fiscal year (FY) 2024 was 22.6 percent while the nationwide rate at VA regional offices was 7.5 percent. Further, in response to an almost 10 percentage point drop in accuracy from FY 2019 to FY 2024, the Compensation Service began quarterly quality spot checks on military sexual trauma claims, which showed denials accuracy improved but remained below the 96 percent goal. The OIG also found that about 34 percent of denied claims contained an error despite the designated reviewer agreeing with the incorrect decision. In addition, fewer claim denials than grants were reviewed in the two-signature process even though quality reviews showed denied claims had more errors. VBA concurred with the OIG's three recommendations.

Financial Efficiency

A Summary of OIG Postaward Contract Reports Issued in Fiscal Years 2023 and 2024 on Vendors' Noncompliance with VA Federal Supply Schedule (FSS) Contracts

The OIG receives requests from VA's National Acquisition Center to validate vendors' data and compliance with FSS contract terms and conditions. The VA FSS program supports the acquisition needs of VA and other government agencies for medical equipment, supplies, pharmaceuticals, and services by contracting with vendors that provide the items at a discount. The OIG reports its findings to the National Acquisition Center, but the reports are not published because they contain sensitive commercial information. This report summarizes 20 reports the OIG issued to the National Acquisition Center in FYs 2023 and 2024. The report presents overall

findings in three areas: vendors' compliance with FSS terms and conditions, noncompliance that could be pursued under the False Claims Act, and net overcharges to the government. The OIG's findings and recommendations helped VA collect about $19.5 million in net overcharges.

A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2024 on VA FSS Pharmaceutical Proposals

The OIG helps VA contracting officers negotiate fair prices by examining pharmaceutical proposals submitted for FSS contracts. The OIG's reports on individual proposals are also not published because they contain legally protected information. This report summarizes the 14 preaward reports provided to VA contracting officers in FY 2024. The 14 proposals had a cumulative value of approximately $34.4 billion and included 1,361 offered items. The OIG found that commercial sales practice disclosures were accurate, complete, and current for six proposals. The remaining eight could not be used for negotiations until deficiencies were corrected. The OIG determined that proposed tracking customers for all sampled items were suitable for the price reductions clause. Tracking customers serve as a benchmark for potential price reductions during the life of a contract. If tracking customers receive a price reduction, the government's price should also be reduced. The OIG recommended lower prices than offered for five proposals, assisting contracting officers in obtaining approximately $36.8 million in savings for VA over the life of the contracts.

A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2024 on VA FSS Nonpharmaceutical Proposals

The OIG also examines nonpharmaceutical proposals submitted for FSS contracts to help VA attain fair prices for the government and save taxpayer dollars. Once more, reports on individual proposals are not published because they contain legally protected information. This report summarizes the 22 preaward reports provided to VA contracting officers in FY 2024 with a cumulative value of $1.8 billion for approximately 44,802 offered items. Commercial sales practice disclosures were accurate, complete, and current for four proposals. The remaining 18 could not be used for negotiations until deficiencies were cured. The OIG determined that proposed tracking customers for two sampled items were not suitable for the price reductions clause. The OIG recommended lower prices than offered for 15 proposals, resulting in approximately $17.4 million in savings for VA over the life of the contracts.

Information Technology

VA Needs to Prioritize Accessibility for Individuals with Disabilities When Procuring Information Technology Systems

To comply with Section 508 of the Rehabilitation Act of 1973, VA must make information—and the communication technology that it uses—accessible to veterans and other individuals with

disabilities. The OIG conducted this audit to follow up on a 2024 report that concluded VA's implementation and monitoring of Section 508 requirements could be improved and to evaluate whether the procurement process for information and communication technology meets Section 508 standards. The OIG found for a sample of 30 systems that VA officials did not ensure the information technology they procured would meet the accessibility standards required by law. The team also found that, although market research was done on vendors that could meet business requirements, contracting officers and the designated officials for VA program offices did not verify the systems were accessible to individuals with disabilities. The OIG issued four recommendations for VA to correct identified deficiencies.

Management Advisory Memorandum

VBA Did Not Take All Corrective Actions for Veterans Prematurely Denied Service Connection for Conditions That Could Be Associated with Burn Pit Exposure

A July 2022 OIG report found that VBA staff prematurely denied service-connected compensation to veterans with conditions that could be associated with burn pit exposure. VBA implemented five recommendations from this report, which the OIG closed. In May and August 2024, VBA requested closure of the remaining two recommendations, which were to review two datasets believed to contain prematurely denied claims, correct any errors, and certify completion. As detailed in this management advisory memorandum, the OIG determined VBA did not take required corrective actions on at least an estimated 25 percent of veterans' denied claims related to burn pit exposure. Therefore, the OIG did not close recommendations 2 and 3 from the July 2022 report; the OIG will continue monitoring VBA's progress and request quarterly updates on how VBA is appropriately remediating all errors and ensuring corrective actions are taken.

Benefits

Delays in Pension Automation Updates Led to Some Burial Transportation Benefits Being Incorrectly Processed

VBA uses an automation system to process benefits for burial expenses, plot costs, and transportation fees for conveying a veteran's remains. The VA OIG conducted this review to determine whether this system is accurately processing claims. Based on a statistical sample of claims from January 5, 2023, through March 31, 2024, the OIG estimated 83 percent contained an error, resulting in about $1.9 million in underpayments to survivors. Although the system correctly processed most burial and plot allowances, an estimated 9,800 transportation claims were improperly processed. The team identified three types of errors: the automated system prematurely denied claims, some approved transportation claims were never reimbursed, and the

notification letter to claimants did not provide a decision on transportation reimbursement. These errors occurred (1) because the system did not have rules to ensure transportation benefits were properly processed and (2) because of inconsistent guidance in VBA policy. VBA concurred with the OIG's two recommendations to address these deficiencies.

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 prompted by OIG hotline complaints, congressional requests, and other leads. The office also inspects vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections issued the following reports in July.

Healthcare Inspections

Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota

The OIG evaluated facility leaders' responses to surgical care concerns related to two facility surgeons at the St. Cloud VA Medical Center in Minnesota. Findings include that the surgical service chief failed to ensure one surgeon's application for privileges included recent surgical case volume and case mix. Additionally, the surgeon was not directly observed to ensure competency with surgical procedures. The OIG determined that facility leaders failed to initiate reporting of the surgeon to the state licensing board when clinical care concerns were identified. In addition, facility surgeons' ongoing professional practice evaluations did not include operating room surgical procedures, and the surgical service chief was clinically inactive for the first two years of employment. The report's four recommendations relate to the review of surgical service credentialing and privileging processes, performance evaluations, and state licensing board reporting processes.

Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore

This healthcare inspection assessed the impact of additional staffing on patient access to care in the community through the VA Maryland Health Care System in Baltimore. The OIG found high consult volume contributed to the system's inability to schedule and complete community care consults in a timely manner and to consistently coordinate care. Limited staffing delayed implementation of the Referral Coordination Initiative. Also, the Patient Advocate Tracking System complaints lacked corresponding action plans for quality improvement. Veterans Integrated Service Network (VISN) leaders were aware of challenges in the Care in the Community program, but they did not help system leaders improve and sustain consult

management performance beyond providing temporary administrative staff assistance. VHA concurred with the OIG's seven recommendations related to appointment scheduling, education and process improvement, implementation of the Referral Coordination Initiative, and analysis of patient advocate tracking system data.

Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington

After evaluating the Everett Vet Center's crisis management of a client, the OIG determined the center's director and a counselor inadequately managed the client's crisis. This included failing to notify law enforcement authorities, not seeking external consultation from a support facility, and delaying crisis reporting. The counselor did not update the client's safety plan or document a risk assessment in a timely manner. Readjustment Counseling Service (RCS) leaders did not provide a written policy clarifying the requirements for crisis reporting and monitoring or clinical record and risk assessment documentation. The OIG received conflicting information from RCS and district 5, zone 1 (district) leaders regarding the vet center director's position description that may have contributed to the director's failure to consult immediately with a district leader. The OIG made four recommendations to the RCS chief officer and five district-level recommendations to correct identified deficiencies.

Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo

The inspection at the VA Western New York Healthcare System related to the care of a community living center (CLC) resident in Batavia, New York. The resident, admitted for dementia-related behaviors, had an elevated fingerstick blood sugar level on day 20 in the CLC, which was left untreated. Three days later, the resident required intensive care for a blood sugar level more than four times the upper limit of normal and subsequently died in hospice care. The OIG substantiated that ongoing and cumulative deficiencies in CLC staff's management of the resident's dementia and diabetes may have contributed to the preventable decline. The OIG also found similar deficiencies in care for a second resident and identified concerns regarding leaders' responses. Further, the deficiencies were identified in provider staffing and nurse education that may have contributed to the first resident's decline. VA agreed with the OIG's 10 recommendations.

Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque

This VA New Mexico Healthcare System inspection assessed allegations and concerns related to the care provided to a patient who was labeled as ineligible for care at the facility, as well as senior leaders' responses. The patient was admitted to the facility twice in 2024. The OIG found that knowledge and communication deficits among responsible staff contributed to multiple

deficiencies related to postsurgical follow-up care, admission, discharge, and escalation of concerns. Staff missed opportunities to correct the patient's financial information during both admissions, which could have resulted in the patient becoming eligible to receive care at the facility. The OIG also found deficiencies with senior leaders' responses to the patient's second discharge and in the supervision of first-year podiatry residents. The facility director concurred with the OIG's 15 recommendations.

Care in the Community Inspection

The OIG Care in the Community program evaluates selected performance elements of the VHA Veterans Community Care Program. The resulting reports describe selected care coordination activities required to initiate and process referrals for non-VA care (community care). The OIG evaluated the following facilities in five areas: (1) leadership and administration of community care, (2) administratively closed community care consults (referrals), (3) community care provider requests for additional services, (4) care coordination activities for patients referred for community care, and (5) community urgent care coordination and management.[1]

Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan

This report describes the results of a focused evaluation of community care processes at eight medical facilities with a community care program in VISN 10. The OIG issued 16 recommendations for VA to correct identified deficiencies in five areas:

- Leadership and administration of community care: These included community oversight councils; community care clinical staffing needs; patient safety events; patient safety trends, lessons learned, and corrective actions; and community care document importing.
- Administratively closed community care consults: Concerns related to community care appointment confirmation and medical documents.
- Community care provider requests for additional services: Weaknesses were found in request processing, request incorporation in the electronic health record, provider signature verification, and approval letters for community providers and patients.
- Care coordination activities for patients referred for community care: The community care–care coordination plan note was not used to document care coordination activities and appointment attendance confirmation.

[1] Under specific circumstances, a consult may be administratively closed when documentation from the community care provider is not provided to VA.

- Community urgent care coordination and management: There were lapses in the urgent care visit notification process and community care–urgent care record note creation.

Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare

This evaluation focused on community care processes at eight medical facilities with a community care program in VISN 4. The OIG issued 13 recommendations for VA to correct identified deficiencies in five areas (some of which were also found in VISN 10):

- Leadership and administration of community care: Issues detected related to community care oversight councils; staffing tool reassessments; patient safety events; patient safety trends, lessons learned, and corrective actions; and community care document importing.
- Administratively closed community care consults: There were weaknesses in community care appointment confirmation and medical documentation.
- Community care provider requests for additional services: Weaknesses were found in request processing and approval and denial letters for community providers and patients.
- Care coordination activities for patients referred for community care: The community care–care coordination plan note was not used to document care coordination activities and appointment attendance confirmation.
- Community urgent care coordination and management: There were lapses in community care–urgent care record note creation.

Healthcare Facility Inspections

The Healthcare Facility Inspections Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care provided in five areas: (1) culture, (2) environment of care, (3) patient safety, (4) primary care, and (5) veteran-centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, in addition to the well-being of patients and staff. July's healthcare facility inspection reports examined the following facilities:

- VA Connecticut Healthcare System in West Haven
- Sheridan VA Health Care System in Wyoming
- VA Coatesville Healthcare System in Pennsylvania
- VA Boston Healthcare System in Massachusetts

Featured Hotline Case

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

Inadequate Mental Health Care Contributed to a Veteran's Death by Suicide

The VA OIG Hotline received allegations that inadequate mental health care at the VA outpatient clinic in Pueblo, Colorado, contributed to a discharged veteran's death by suicide. The hotline team asked officials at the VA Eastern Colorado Health Care System in Aurora, Colorado, to review the matter and provide information back to the OIG as requested. The VA medical center review substantiated the allegations and found the veteran's care team failed to review his available health history and there were significant delays in scheduling the veteran's initial mental health consult. During the veteran's initial appointment with his care team, the primary care provider (PCP) identified the need for mental health support, placed a consult (referral) to the mental health clinic, and prescribed a controlled medication. However, the PCP failed to conduct a full review of the veteran's previous Department of Defense and VA treatment records. Had the PCP referenced prior medical records, the physician would have seen the veteran's military records had an extensive suicide risk history, including attempts in the recent past. This information would have indicated additional intervention was necessary, including same-day access to mental health care. The VA medical center review also found that the mental health consult entered by the PCP went unscheduled for several months.

Tragically, the veteran died by suicide two weeks before his scheduled appointment. To address these failings: (1) facility medical providers were reeducated on requirements for reviewing the medical history for new patients and initiating or adjusting psychiatric medications; (2) mental health schedulers are being trained to document at least three outreach attempts and send a follow-up letter within 28 days of consult placement; and (3) facility administrators will regularly monitor processes for open consults to verify outreach attempts occurred, with regular audits for compliance.

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To listen to the podcast on the July 2025 highlights, go to the podcasts page on the OIG website.