SEPTEMBER 2025 HIGHLIGHTS

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 developments in September.

Healthcare Investigations

Former Nurse at the Muskogee VA Medical Center Sentenced for Drug Diversion

A VA OIG and VA Police Service investigation revealed that a VA nurse diverted about 130 hydrocodone pills for her own personal use from the medical center's automated medication management machines while on duty over the span of four months. She was removed from her position in November 2024. The former nurse was sentenced in the Eastern District of Oklahoma to 24 months' probation after pleading guilty to acquiring hydrocodone by misrepresentation, fraud, forgery, and deception.

Benefits Investigations

Four Individuals Connected to a House of Prayer Affiliate Indicted in Connection with Education Benefits Fraud Scheme

A multiagency investigation resulted in charges alleging that from at least 2011 through 2022, four leaders of Georgia affiliates of the House of Prayer Christian Churches of America conspired to defraud VA and veterans of millions of dollars in education benefits. According to the indictment, these leaders fraudulently obtained a religious exemption from state regulators in Georgia to operate two of five locations in the state as the affiliate called the House of Prayer Bible Seminary (HOPBS). This exemption required that Georgia seminaries not receive federal funds. Yet the four defendants applied for and accepted VA education benefits, making the seminary ineligible for the exemption. The defendants recruited military personnel to the church, directed them to enroll in HOPBS, and then used VA benefits for personal gain. HOPBS received more than $3 million in education benefits for its two Georgia locations and more than $23.5 million for all five locations. From 2013 through 2021, the four leaders fraudulently submitted false certifications to Georgia regulators that claimed the seminary did not receive federal funds. The scheme channeled funding from VA education benefits to seminary accounts, which the defendants in turn siphoned off for their own use. As a result, some veterans' benefits were exhausted, often without the veterans completing their programs. The four defendants were indicted in the Southern District of Georgia on multiple criminal charges. Two of the four

defendants, along with two additional individuals, were also indicted in connection with a long-running mortgage fraud conspiracy that was partially tied to VA home loans. In total, eight defendants were indicted for both the education and mortgage fraud schemes. This investigation was conducted by the VA OIG, FBI, Internal Revenue Service Criminal Investigation, Federal Housing Finance Authority OIG, Army Criminal Investigation Division, US Citizenship and Immigration Services, and US Postal Inspection Service

School Official Sentenced in Connection with $2.9 Million Scheme to Defraud VA Education Programs

A career services manager for a school offering training programs to veterans was sentenced after pleading guilty to wire fraud. The VA OIG investigation revealed that between July 2022 and May 2024, the manager used false records to defraud VA of millions of dollars. The manager fabricated veterans' employment offer letters, falsified certifications, and forged veterans' signatures on employment certification forms to make it appear as if veterans had attained the meaningful employment needed for the school to receive tuition payments from VA. On behalf of the school, the manager caused hundreds of false documents to be submitted to VA that fraudulently claimed more than $2.9 million in tuition payments for about 189 students. Of this amount, VA paid more than $2 million. The manager was sentenced in the Eastern District of Virginia to 42 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $1.3 million. A consent order of forfeiture was previously issued to the school for about $699,000 in cash.

Veteran Found Guilty of Aggravated Identity Theft

An investigation by the VA OIG and Social Security Administration OIG resulted in charges alleging that a Navy veteran stole the identity of an Army veteran and used it for over 20 years to fraudulently obtain more than $1 million in VA healthcare and compensation benefits. He obtained the Army veteran's personal information, including military personnel records, after meeting and offering to write a book about him. He then allegedly submitted a fraudulent claim for VA compensation benefits that described the Army veteran's combat in Vietnam. The Navy veteran never applied for VA compensation benefits related to his own military service. He also obtained driver's licenses, applied for Social Security Administration benefits, and got married using the Army veteran's identity. He was found guilty in the Eastern District of Washington of aggravated identity theft.

Veteran Pleaded Guilty to Compensation Benefits Fraud Scheme

A VA OIG and FBI investigation revealed that from 2013 through 2022, a veteran fraudulently received VA disability compensation and individual unemployability benefits. The veteran repeatedly stated to VHA physicians and VBA employees that he had difficulty walking, could

not climb stairs, and was unable to obtain meaningful employment due to his medical conditions. During the time he claimed to be unable to work, the veteran received his black belt in kickboxing, participated in challenging running events, trained extensively with a personal trainer, and owned several businesses. The loss to VA is more than $403,000. The veteran pleaded guilty in the Eastern District of Pennsylvania to theft of government funds.

Son of Deceased VA Beneficiary Pleaded Guilty to Theft of Government Funds

The son of a deceased VA beneficiary continued to receive VA dependency and indemnity compensation benefits intended for his mother following her death in November 2008. During an interview with agents, he acknowledged using the funds for his personal expenses. He pleaded guilty in the District of New Jersey to theft of government funds. The loss to VA is more than $256,000. The VA OIG and FBI investigated this case.

Former VA Fiduciary and Spouse Indicted in Connection with Theft Scheme

A VA OIG investigation resulted in charges alleging that between April 2018 and October 2020, a VA-appointed fiduciary and his spouse comingled VA funds that were intended for a veteran with their own personal funds. They used the veteran's funds to purchase personal items and pay their own expenses. The VA removed the fiduciary's appointment in September 2020, then referred the case to the VA OIG in June 2021. The total loss to VA is about $182,000. The defendants were indicted in the Southern District of Alabama on charges of theft of government funds and misappropriation by fiduciaries.

Individual Arrested for Murdering Veteran and Stealing His VA Compensation Benefits

An investigation by the VA OIG and Pueblo County (Colorado) Sheriff's Office prompted charges alleging that an individual murdered a veteran and then withdrew and spent about $75,000 of the veteran's VA disability compensation benefits. The veteran's dismembered body was discovered in a shallow grave on a property owned by one of the individual's relatives in eastern Pueblo County. The individual was charged in the 10th Judicial Circuit Court of Colorado with murder, identity theft, and theft.

Investigations Involving Other Matters

Nonprofit Director of a Veterans' Homeless Shelter and Service Facility Pleaded Guilty to Federal Program Theft

A former CEO and executive director of a nonprofit corporation serving as a veterans' homeless shelter and service facility pleaded guilty to diverting grant funds for his own personal use. The VA and the Department of Labor (DOL) awarded grants totaling $1.8 million to the shelter to support homeless veterans. The director diverted $180,000 of the funds and spent the money on

personal expenses, including his vehicle, lawn equipment, and rental property. He pleaded guilty in the Southern District of Texas to federal program theft. This multiagency investigation was conducted by the VA OIG, DOL OIG, and Texas Department of Public Safety.

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

Not All VA Disability Compensation Examiners Completed Training Before Providing PACT Act Medical Opinions

VHA disability compensation examiners and VBA contract examiners must complete training before conducting disability compensation medical examinations. The OIG conducted this review to determine whether examiners are complying with training requirements, including recently added PACT Act training. The team found that 29 of 100 VHA medical opinions reviewed were provided before PACT Act training was completed. From this number, the team estimated that VHA disability compensation examiners provided 8,600 PACT Act medical opinions during calendar year 2023 before completing PACT Act training. VHA established August 1, 2023, as the training completion deadline, and the issue of examiners providing opinions without training was mostly resolved by this date. Generally, compared to VHA examiners, more VBA contract examiners completed PACT Act training before providing medical opinions. VBA concurred with the OIG's recommendation to ensure an independent assessment and medical opinion is provided for cases identified during this review.

Inadequate Oversight Allowed a Senior Benefits Representative to Inaccurately Authorize Thousands of Decisions

The OIG substantiated a hotline allegation that a senior veterans service representative in Philadelphia approved hundreds of rating decisions for claims each day without conducting the required reviews. In fiscal years 2022 through 2024, this employee authorized about 85,300 claims—19 times the national average—and contributed more than 35 percent each year toward the regional office's claims completion goal. The team estimated that about 13,200 of the rating decisions (84 percent) authorized by this employee from January through June 2024 had at least one error. These errors resulted in an estimated $2.2 million in improper payments. VBA officials at the regional, district, and central offices knew about the employee's unusually high

authorization rate. However, they did not effectively respond to the associated risks. VA concurred with the OIG's two recommendations to correct the errors and evaluate internal controls.

Better Controls Needed to Accurately Determine Decisions for Veterans' Nonpresumptive Conditions Involving Toxic Exposure Under the PACT Act

In 2022, the PACT Act expanded veterans' eligibility for benefits and services for conditions related to toxic exposure during military service. This complicated VBA's claims determination process for nonpresumptive conditions—when service connection cannot be granted on a presumptive basis. The law opened a new path for service connection for veterans with nonpresumptive conditions related to toxic exposure risk activity (TERA). This OIG review, conducted from October 2023 through May 2025, examined whether staff processed decisions in compliance with TERA procedures under the PACT Act that denied nonpresumptive conditions. VBA's oversight lagged in ensuring accurate processing of nonpresumptive conditions under the PACT Act. The OIG estimated that 61 percent of all nonpresumptive, TERA-related decisions under the PACT Act that VBA denied from May through August 2023 had processing errors—potentially affecting veterans' benefits. Furthermore, PACT Act guidance is difficult for staff to navigate. VBA concurred with the OIG's three recommendations.

The Accuracy of Veteran Readiness and Employment Claims Cannot Be Assessed Because of Insufficient Documentation

Veteran Readiness and Employment (VR&E) provides job training to rehabilitate veterans whose service-connected disability prevents them from gaining and keeping suitable employment. The OIG reviewed claims processed from April 1, 2023, through September 30, 2023, and found that although the VR&E manual and staff training generally capture the regulatory requirements for determining veterans' eligibility and entitlement, VR&E counselors did not clearly document their decisions when processing benefit claims. The evidence available to the OIG to support claims was insufficient to assess the accuracy of decisions, resulting in $309.5 million in questioned costs. Also, VR&E has not asked VA's Office of General Counsel to comprehensively review VR&E's eligibility and entitlement process, meaning the program may not be conforming with all legal requirements. VBA concurred with the OIG's five recommendations to address the problems identified so that only eligible veterans entitled to VR&E benefits receive them.

Healthcare Access and Administration

Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians

As directed under the MISSION Act, VA created clinical resource hubs to improve healthcare access for veterans in underserved areas. The hubs support medical facilities in each VISN that do not have enough clinical staff. Hub physicians see patients mostly virtually. The OIG found that despite a steady increase in patient encounters since 2021, physicians in some hub primary care and specialty group practices—such as cardiologists, dermatologists, psychiatrists, and psychologists—generally did not appear to meet established minimum productivity thresholds. The apparent failure to meet these thresholds may have been caused by gaps and inaccuracies in the data used to measure productivity. The OIG recommended VHA improve data, issue guidance on which productivity measures apply to hub physicians and clarify who should monitor and enforce them. VHA agreed to implement the recommendations.

Loma Linda Healthcare System's Oversight of Community-Based Outpatient Clinic Contracts Needs Strengthening

This review assessed contract oversight of staffing and appointment cancellation performance measures at five Loma Linda Healthcare System community-based outpatient clinics (CBOCs) in California. The OIG found that VA leaders in the Loma Linda Healthcare System did not ensure contractor compliance with performance standards for staffing or for the number of appointments canceled by the clinics during fiscal years 2022 and 2023. Furthermore, this review found that the contracting officer's attempt to recover government funds associated with using VA personnel to cover shortages at the contracted clinics was insufficient. Contract noncompliance occurred, in part, because the assistant director did not provide effective oversight of the contracting officer's representative or the CBOC nurse coordinator. The OIG made nine recommendations for VA to improve oversight of CBOC contracts.

Facility Maintenance and Construction

The Emergency Department Construction Project at the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, Did Not Follow VA and Industry Equipment Design Standards

The OIG confirmed a hotline allegation that the 2024 emergency department expansion and renovation at the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, did not meet standards. Fast-track exam rooms, used to quickly assess and treat patients with minor injuries or illnesses, did not have permanent medical air, oxygen, and vacuum outlets, nor did all the rooms have acceptable exam lights. In addition, in one room the contractor failed to install

the required plumbing for permanent medical air, oxygen, and vacuum lines. VA officials agreed with the OIG's four recommendations to ensure guidance is in place for the Office of Construction and Facilities Management to provide appropriate oversight of minor construction projects, to revise the VHA directive on minor construction projects to incorporate legal requirements, to review emergency department exam and fast-track rooms for compliance with standards, and to review an assessment of the emergency department for compliance with design and equipment requirements.

Weak Governance Threatens the Viability of a Major Construction Project at the Palo Alto VA Medical Center in California

The Palo Alto major construction project was originally intended to provide ambulatory care, polytrauma care, and seismic safety at the Palo Alto Health Care System. But the project's cost and timeline have increased since it began. The OIG conducted this review to evaluate the significant events that led to cost increases, schedule slippages, and scope changes. The review found that inadequate governance has kept VA from achieving two of its three critical project objectives, putting the project more than 21 years behind schedule and requiring scope and cost increases. Additionally, because VA did not provide adequate justification for a significant scope increase proposed in the fiscal year 2012 budget, the OIG questioned the expenditure of about $716.6 million. To prevent further waste, VA leaders must either strengthen governance of the project or consider canceling it. VA concurred with the OIG's four recommendations.

Financial Efficiency

Facilities Need to Fully Implement VHA's Strategic Planning and Request Process for Nonexpendable Medical Equipment

The OIG conducted this audit to determine whether medical facilities followed VHA's process to plan, request, and approve nonexpendable medical equipment purchases. Nonexpendable equipment typically has a useful life of two years or more and costs at least $300. Ventilators, radiology equipment, and vital sign monitors are examples. VHA's process requires facilities to use the Strategic Equipment Planning Guide and Enterprise Equipment Request portal, which supports streamlined planning and expedites approval of equipment orders. From October 1, 2022, through May 15, 2024, VHA staff entered requests into the guide to buy about $2.1 billion in medical equipment. The OIG found that medical facilities did not use the required process for all planning and approval, and some VHA facilities still had not fully implemented the process (mandated in fiscal year 2017) as of fiscal year 2024. The OIG made five recommendations to correct identified deficiencies.

Improved Oversight of VHA's Nonexpendable Equipment Is Needed

In a companion report, VHA's nonexpendable equipment must be inventoried annually. This OIG audit assessed whether VHA managed accountable nonexpendable equipment in accordance with policy. The OIG estimated that 75,500 items (5 percent) could not be accounted for. These items had a collective value of at least $210.9 million—funds VA could have put to better use. The audit team also estimated 537,000 items (33 percent) were in different locations than inventoried and an estimated 62,500 items may not be needed. These tracking issues were created, in part, by staff's use of the inventory-by-exception process. This means that if an item was accounted for since the last annual inventory—because it needed maintenance, for example—it does not need to be included in the next scheduled annual inventory. The OIG also found that reports of survey processes for missing or damaged items have not been conducted. VA concurred with the OIG's six recommendations to improve the nonexpendable equipment inventory process and oversight.

Summary of Fiscal Year 2024 Preaward Audits for Healthcare Resource Proposals from Affiliates

VA 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 fiscal year 2024, the OIG completed 16 audits of proposals with a combined estimated value of about $300.6 million, identifying more than $121.7 million in potential savings. Following the OIG audits, VHA sustained about $47.5 million in cost savings. For 13 of the 15 proposals with full-time-equivalent pricing, the prices offered to the government for hourly rate pricing were higher than supported amounts. One proposal had per-procedure pricing and offered per-procedure rates higher than Medicare rates. Finally, the OIG found potential conflicts of interest in six of the 16 proposals reviewed.

VHA Did Not Effectively Oversee the Use of Manual Journal Vouchers

From October 2023 through September 2024, VHA processed almost 114,000 manual journal vouchers, representing about $71.2 billion in healthcare-related accounting transactions. Manual journal vouchers are used to record salary accruals, expenditure transfers, and other adjustments that cannot be automated. Although intended to support accurate records, these journal vouchers introduce the risk of error and misclassification because they rely on manual input. The OIG found that staff at 172 medical centers did not follow VHA financial policy in processing manual journal vouchers. The OIG estimated that 76 percent of manual journal vouchers lacked one or more required elements, such as clear justification, and estimated that at least $27 billion in transactions were processed using manual journal vouchers that lacked the required documentation or approvals. VHA concurred with the OIG's four recommendations to help

VHA reduce the risk of misstatements and increase transparency and accountability in its financial reporting.

Management Advisory Memorandum

Documentation Deficiencies for Electronic Health Record Interface Testing at the Lovell Federal Health Care Center in North Chicago

This management advisory memorandum outlines the OIG's observations about testing procedures on electronic health record (EHR) interfaces at the Lovell Federal Health Care Center, where VA had to synchronize the rollout with the Department of War system before going live March 9, 2024. The OIG confirmed VA and the contractor, Oracle Health, performed the correct tests and applicable retesting on the 24 interfaces reviewed, but they did not provide documentation important for future EHR deployments. Documentation did not show testing had been done with the Financial Management System interface, which bridges the EHR system and VA's payment and billing system, before going live. The notation "no run," which means no test steps were run, was used with the notation "passed" for four interfaces that exchange information on imaging, patient movement, bed management, and surgical instruments. Finally, two interfaces did not support VA–Department of War functionality because joint workflows at the facility were not included in testing procedures.

Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans

The purpose of this memorandum is to help VHA address costs and potential issues about treatment duration and quality of care for residential substance use disorder treatment provided under community care contracts. The OIG found VHA amended contracts to require billing codes for one third-party administrator (TPA), but negotiations continue with the other TPA, which received more than $268 million in overpayments in fiscal years 2023 and 2024. The OIG is concerned that lax oversight could lead to VHA overpaying TPAs when providers bill for treatment that needlessly lengthens a veteran's residential care. Another concern is the quality of care that veterans receive in the community for these services. VHA should apply the contract changes it made with the first TPA to all its community care contracts and consider consulting with mental health staff at authorizing VA facilities on improving the care veterans receive in the community.

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 September.

Featured Report

Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes

The OIG conducted a national review to evaluate the alignment of information related to mental health, substance use disorder (SUD), and suicide risk treatment needs within VHA's Homeless Operations Management and Evaluation System (HOMES) data collection system and electronic health record (EHR). The OIG also assessed homeless program staff's adherence to suicide risk screening procedures and care coordination. Homeless program staff did not document the HOMES Assessment in 42 percent of patient EHRs, which limited access to important clinical information among clinicians outside of VA homeless programs. The OIG found that 85 percent of patient EHRs included a suicide risk screening at the time of the HOMES Assessment or in the 30 days prior, as required. However, VHA has not implemented processes to ensure that staff complete the required suicide risk procedures, including risk mitigation, in response to HOMES-identified risk of self-harm. Homeless program staff did not document care coordination as outlined in VA homeless program policy. The OIG found that 35 percent of patients with HOMES-identified treatment needs, who were interested in participating in treatment, had EHR documentation of care coordination related to those treatment needs. VHA homeless program strategic goals include coordinating care to address veterans' mental health and SUD needs; however, VHA has not delineated responsibility for ensuring care coordination, resulting in a lack of oversight and risk of patients not receiving needed mental health and SUD treatment. The OIG made four recommendations to the under secretary for health related to consistent EHR documentation of HOMES clinical information, suicide risk screening at intake, suicide risk screening in response to danger of self-harm identified in the HOMES Assessment, and documentation of mental health and SUD care coordination.

Healthcare Inspections

Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina

Inspection staff reviewed allegations about internal endocrine consult management, endocrine clinic utilization, and patient access to gender-affirming hormone therapy. The team also reviewed leaders' awareness of and response to these concerns. The OIG substantiated that the chief of medicine (COM) did not effectively manage internal endocrine consults. The COM's deficient management of endocrine consults negatively impacted endocrine clinic utilization and resulted in provider-created workarounds and patients not receiving timely endocrine

appointments. The OIG found that patient access to gender-affirming hormone therapy was delayed because of the COM's actions. Additionally, the COM's interpersonal communication skills did not reflect VHA high reliability organization values and negatively affected system staff. The VISN director and system director concurred with and provided an action plan to address the OIG's seven recommendations.

Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens

This healthcare inspection examined whether staff and leaders followed required procedures related to suspected elder abuse of a community living center resident. Leaders and staff failed to report suspected resident abuse to a supervisor, the unit social worker, VA Police, the resident's family, and state authorities. A provider did not document a complete exam of the resident, consider whether bruises were abuse-related, or inform the resident's family. Nursing leaders failed to immediately ensure the resident's safety and thoroughly investigate the matter. Staff described a culture of silence in the community living center. The OIG found additional reporting deficiencies related to other incidents of suspected abuse; insufficient staff training; substandard documentation; and omissions in VHA and system abuse-related policies. The OIG issued seven recommendations for VA to correct identified deficiencies. VA agreed with six of the recommendations and concurred in principle with one recommendation.

Healthcare Facility Inspections

The Healthcare Facility Inspections (HFI) Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care provided using 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. September's HFI reports examined the following VA systems:

- Jackson Healthcare System in Mississippi
- Alexandria Healthcare System in Pineville, Louisiana
- Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington
- West Palm Beach VA Healthcare System in Florida

Featured Hotline Case

The OIG Hotline Division receives, triages, and coordinates action on allegations of criminal activity, waste, abuse, violations of VA policy, and major mismanagement involving VA programs and operations. Matters not selected for immediate OIG review may be referred to VA to investigate and report back to the OIG on its findings. VA has written policy to receive, review, document, and respond to OIG hotline case referrals. OIG subject matter experts then assess VA's response for adequacy before either closing the case or escalating it for possible action by one of the OIG's directorates (especially if responses indicate there may be a systems-level problem).

This collaborative process between the OIG and VA enables a broader review of reported concerns, helping to ensure that as many issues as possible receive appropriate attention. It is a vital function that supports accountability, responsiveness, and the protection of veterans and other stakeholders who rely on VA services. OIG staff dedicate considerable time to reviewing VA's responses to case referrals and provide summaries of these cases to promote transparency and public awareness.

VA Medical Facility Substantiated Allegations That Inadequate Health Care Contributed to a Veteran Experiencing a Heart Attack

Hotline staff received allegations that a veteran was provided inadequate health care at the Central Alabama VA Medical Center in Montgomery, which contributed to the veteran suffering a heart attack in February 2025. The hotline complainant alleged that in the two years preceding the heart attack, the veteran reported experiencing chronic fatigue and pain in the back of their head. The veteran's VA primary care provider had referred the veteran to VA cardiology service in September 2024; however, the recommended follow-up test was not scheduled for the veteran after the cardiology appointment. In February 2025, the veteran was seen in the medical center emergency room with headache and dizziness and was transferred to a community hospital for a cardiac catheterization where significant cardiac disease was found. The veteran experienced complications after the cardiac catheterization, which required transferring the veteran to another hospital for emergent vascular surgery. The veteran survived the surgery and will be seen by a community care cardiologist at the request of the veteran going forward. Hotline staff referred the matter to the medical center for review, which substantiated the allegations, finding that the cardiologist documented that the veteran needed a cardiac stress test but failed to order one. To address these deficiencies, the medical center's deputy chief of staff provided a clinical

disclosure to the veteran regarding the failure to perform the stress test, and the cardiologist received training on the importance of timely testing.

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