US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

Fiscal Year 2025 Inspector General's Report on VA's Major Management and Performance Challenges

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Foreword

The mission of the Office of Inspector General (OIG) is to serve veterans and taxpayers by conducting impactful, independent oversight of VA programs, operations, and services. Each year, as mandated by the Reports Consolidation Act of 2000, the inspector general summarizes the top VA management and performance challenges identified by OIG work and assesses the department's progress in addressing them.

The major management challenges that VA faced in fiscal year (FY) 2025 continue to align with the OIG's strategic goals within five areas of concern: (1) health care, (2) benefits, (3) stewardship of taxpayer dollars, (4) information systems and innovation, and (5) governance.

The challenges in these areas have been identified by OIG personnel, with assistance from the veteran community, Congress, and other stakeholders. The OIG remains fully committed to recommending improvements to VA's work on behalf of veterans, and to making impactful recommendations for increased efficiency. The OIG recognizes the challenges VA faces and appreciates the work VA personnel at every level do each day on behalf of veterans, their families, and caregivers.

The department is undergoing transformation while modernizing several massive information technology systems critical to safely and promptly meeting the needs of veterans. This includes continuing the deployment of VA's multibillion-dollar electronic health records system and scaling up a new financial management system. VA is also navigating the use of automation in benefits claims processing and exploring the department's potential uses for artificial intelligence. These efforts test VA's ability to put veterans and their families first while making the best use of taxpayer dollars.

The PACT Act has also led to millions more veterans applying for related benefits, even as VA strives to manage the impact of increased numbers of eligible veterans seeking care within their communities. Several OIG reports illustrate VA's attempts to hold third-party administrators (TPA) and community providers to contract requirements to provide veterans with the prompt critical care they need.

Recruiting and hiring qualified staff, ensuring patient safety, maintaining timely access to high-quality health care, and addressing deficiencies that center around shortfalls in VA governance and accountability are just some of the major management challenges that OIG reports have identified for FY 2025. These challenges also warrant greater attention to VA-wide consistency, communications, and accountability in adhering to governing mandates.

CHERYL L. MASON
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OIG Challenge #1: Healthcare Services

The Veterans Health Administration (VHA) is the largest integrated healthcare system in America and is responsible for providing care to more than 9 million enrolled veterans, which includes an increasingly older population with complex needs. However, VHA has dealt with challenges in ensuring veterans have timely access to health care. OIG reports have documented veterans often experiencing delays with scheduling appointments, inconsistent coordination for referrals to specialty care, and confusion about how to access care in the community. These issues are exacerbated by rising demand and staffing vacancies in hard-to-fill positions, leaving leaders to manage difficult, interrelated challenges that have become more prominent over the last year.

OIG reports have highlighted staffing vacancies that limit the availability of personnel with specific expertise to execute vital healthcare functions—from support services to hands-on patient care. Unfilled positions in nonclinical staff can also directly affect the care patients receive, from scheduling medical appointments to transporting patients to higher levels of care. Leadership vacancies, often filled with interim replacements, may prompt the adoption of a patchwork of temporary solutions for major problems. The difficulty in recruiting and retaining qualified medical personnel can result in consequences such as delays in access to care, diagnoses, and treatment, which increase risks for tragic outcomes.

Effective implementation of the community care program can serve to address staffing vacancies at VHA but also must operate to benefit veterans by providing quality health care. While VHA has taken steps to improve the community care program, it has struggled to ensure seamless coordinated care between VHA and community providers. Repeated gaps in coordination compromise veterans' access to timely and quality health care.

Why This Is a Challenge

Medical center officials have reported concerns regarding occupational staffing that affect aspects of healthcare delivery throughout VA. The OIG's congressionally mandated FY 2025 occupational staffing shortage report noted that all 139 medical facilities reported shortages through a standardized questionnaire (a 50 percent increase over FY 2024). In particular, 94 percent of facilities reported severe shortages for medical officers, and 79 percent reported severe shortages for nurses—with psychologists as the most frequently reported clinical shortage. For nonclinical shortages, police were most frequently reported.

VA is increasing its utilization of community care programs to address, in part, these staffing challenges. Internal VA data show a 12 percent increase in community care referrals from FYs 2024 to 2025. As the demand for community care grows, a related VA challenge is to ensure that the program provides veterans with timely access to quality health care. For example,

VHA must have effective processes to identify veterans eligible for such care, to schedule appointments, and to easily retrieve medical documentation to inform treatment.

However, the OIG has routinely found that community care programs are plagued by issues related to personnel, processes, and VHA oversight at multiple levels. In addition to procedural and oversight deficiencies, lack of qualified staff to manage the escalating volume of community care consults led to scheduling delays, gaps in coordinating care, and not receiving timely exam results. Process noncompliance, such as lack of communication between VA facilities and community providers, contributed to patients not receiving critical diagnostic results or care. Inadequate governance of community care programs permitted long-standing performance deficiencies to persist.

Although VHA has made efforts to improve VA and community care coordination processes, recent OIG reports have identified systemic issues with inadequate monitoring, training, and quality-control checks. For example, VHA created the Veteran Self-Scheduling (VSS) process to enable eligible veterans to make their own community care appointments. However, weak planning and oversight, minimal training, and conflicting field guidance compromised this initiative. Staff placed some veterans—including those with urgent or complex medical needs—into the process without their knowledge. This meant they may not have known to self-schedule their appointments with community care providers, increasing the risk of delayed care or cancelation of the veteran's consult. In addition, although the VSS was used to improve scheduling metrics, there was no accurate way to validate whether the process shortened wait times because it could not reliably capture the actual date a veteran scheduled an appointment.

Another OIG report found that Veterans Integrated Service Network (VISN) facility schedulers did not always ensure eligible veterans were appropriately identified and offered all care options within and outside VA. Schedulers lacked an effective process to get information on available appointments at other VA medical facilities, either inside or outside the VISN, when services could not be provided in a timely manner or were unavailable at veterans' regular facilities.

Department's Corrective Actions

VHA has advanced its use of data to verify community care eligibility and track patient outcomes, as well as to modify the scheduling and referral processes in response to VA OIG recommendations. VA has also enhanced the patient experience by launching real-time feedback tools and digital communication platforms. These are important steps, yet there needs to be continued focus in addressing the other identified issues as well, such as improving the timeliness of community care scheduling and VA's continued implementation of its enhanced referral coordination initiative. Additionally, to expedite veterans' access to care, VA announced in May 2025 that community care consults would no longer require review and approval by a second physician. The OIG will continue to monitor the effect these changes have on patient wait times.

Responsive to OIG recommendations, VA leaders have agreed to improvements in community care programs by streamlining processes, closing gaps in communication between providers and patients, and making certain that case management is effective to consistently provide seamless, coordinated care for veterans. VHA leaders have concurred with recommendations to improve referral coordination through clearly defined roles, responsibilities, and performance expectations. VHA is also working to enforce standards for appointment wait times in community care settings and strengthen oversight of third-party administrators to ensure the adequacy of the provider network. Further, supporting care coordination, VA leaders agreed to improve communication about patients who receive urgent community care. VHA continues to act on patient feedback, using survey data to reveal and address gaps in care quality and coordination.

Also responsive to OIG findings, VHA canceled the mandatory requirement for facilities to offer the self-scheduling option to veterans and is evaluating the VSS training program to determine what updates are needed and to confirm schedulers complete training elements. VHA still needs to strengthen its controls and reporting to flag inappropriate VSS use and should devise a reliable way to measure whether the self-scheduling process is meeting its intended goals.

Finally, in response to an executive order mandating a hiring freeze, VA sought and received exemptions to hire personnel critical to providing healthcare services to veterans.

OIG Challenge #2: Benefits for Veterans

The Veterans Benefits Administration (VBA) is tasked with providing millions of veterans, eligible family members, caregivers, and survivors with earned benefits and services, including disability compensation, education benefits and training, and home loan assistance. VBA has long struggled to keep pace with the high volume and complexity of its benefits claims workload; new entitlements stemming from legislative changes have only exacerbated those challenges, negatively affecting both timeliness and accuracy.

The demands for OIG oversight have continued to increase following the passage of the PACT Act of 2022, which provides care and benefits to veterans exposed to burn pits and other toxic substances. According to VA, the PACT Act is perhaps the largest healthcare and benefit expansion in VA history. As of August 9, 2025, according to VA data, nearly 6.4 million veterans received screenings for toxic exposure and claims processors had completed more than 2.6 million PACT Act claims since the law's passage. Also, by August 9, VBA reported a backlog of over 297,000 PACT Act–related claims and over 384,000 pending claims unrelated to the act. The additional workload the PACT Act generated strained the complex claims and benefit-request processes, jeopardized accuracy, and imposed even greater challenges on meeting timeliness standards. The OIG continues to provide oversight of these and a myriad of other types of claims and benefits services. Identified errors in claims processing or awarding services

can delay or improperly deny benefits or support to veterans, their families, survivors, and caregivers.

In addition to achieving claims processing accuracy goals, VBA also faces challenges in ensuring the accuracy of benefit payments. In a May 2025 congressional testimony, the OIG highlighted how the accelerated PACT Act implementation, generally unclear claims-processing guidance, and inadequate quality assurance reviews have continued to result in improper payments across many types of benefits and services within the compensation and pension programs. For the pension program alone, VBA made $518 million in improper payments as reported in VA's FY 2024 Agency Financial Report. Further, gaps in internal controls have hindered VBA's ability to quickly detect and correct improper payments.

Why This Is a Challenge

VBA claims processors must keep up with constantly changing policies, procedures, and laws to decide claims accurately. Weak training programs, inadequate information system tools, and vague or conflicting directions have led to widespread processing errors and poor decision-making. For example, one OIG report found that the lack of clear guidance led to VBA claims processors assigning incorrect effective dates for 31,400 out of 131,000 PACT Act claims (24 percent). In addition, the OIG found $1.4 million in unnecessary costs associated with scheduling unwarranted medical examinations for claims related to denied presumptive disabilities under the PACT Act.

These errors directly affect veterans by resulting in improper payments and claims denials. Each year, VA distributes billions of dollars in compensation and pension benefits. Even a small percentage of improper payments can result in significant financial losses—to both VA and veterans. Making proper determinations for benefit payments is particularly challenging due to the complexity of VA's statutory and process requirements, as well as related criteria and case law, including determining eligibility and making retroactive adjustments. The OIG's data analytics work has also highlighted the inability of some VBA systems to integrate information from related sources, cross-check data, and flag anomalies—further contributing to this challenge.

While VBA has provided education and instruction on claims processing, OIG reports continually find that some training is insufficient or did not include all users' needs. Training programs covering benefits eligibility and processing, especially on complicated programs like the PACT Act, are expected to position staff to efficiently, competently, and accurately support eligibility determinations for veterans. However, VBA did not always use hands-on approaches that reflected real-life scenarios and did not fully assess whether the training improved claims processing.

As OIG reports from prior fiscal years have shown, information technology (IT) enhancements to improve benefits processing have not always yielded the intended outcome. For example, two

of VBA's tools created to help claims processors determine effective dates for claims were not reliable when it came to PACT Act–related calculations. A similar issue was identified in a report on VBA's special monthly compensation calculator (Veterans Benefits Management System for Rating). The review found that the calculator produced inaccurate results, which ultimately resulted in incorrect monthly payments to veterans, until it was disabled by VBA.

Department's Corrective Actions

VBA continues to focus its efforts on addressing OIG recommendations to increase efficiency and improve accuracy in claims processing. These efforts include clarifying guidance identified as confusing or potentially contradictory and better preparing new and current employees to properly navigate a complicated claims review process. For example, VBA completed summary evaluations of the initial PACT Act training to assess its effectiveness in improving staff proficiency. To address processing errors, VBA is making several updates to the existing guidance. VA's Adjudication Procedures Manual now clarifies when claims processors should request medical disability examinations and opinions. Additionally, staff continue to make updates to guidance for reopened survivor Dependency and Indemnity Compensation claims, assigning effective dates for claims, and processing presumptive disabilities. While VBA has made progress, work remains in enhancing and testing tools to ensure applications and automation yield intended outcomes.

VBA has also improved some of its data-matching capabilities in recent years by enhancing the use of Social Security Administration death data and other federal sources to identify deceased beneficiaries quicker. However, OIG reports have noted additional efforts are needed for improvements in claims processing automation. Recently, an OIG report noted that pension automation did not always identify transportation costs related to burial expenses. Although the system correctly processed most burial expenses, 79 percent of claims were incorrect because transportation costs were never reimbursed. This was because the automation system did not include the proper rules to identify and process those costs. VBA responded to the OIG's recommendation by taking steps towards system enhancements that will check for transportation reimbursement eligibility to help mitigate this issue.

Clear guidance, enhanced training and feedback, robust system testing, and better-quality reviews will contribute to improving the accuracy, timeliness, and integrity of the benefits delivery system. This will, in turn, help VA strengthen its stewardship of taxpayer funds and protect veterans and their families from the hardships caused by inaccurate claims processing.

OIG Challenge #3: Stewardship of Taxpayer Dollars

Several challenges VA faces in overseeing its spending are directly related to outdated financial management systems that sometimes lack interoperability and inadequate internal monitoring of its many programs. Each year, VA must distribute hundreds of billions of dollars for direct and

community medical care, disability payments, education and survivor benefits, memorial services, cemetery grounds maintenance, and a wide range of other benefits and services in addition to supporting programs and operations. Benefits and services are delivered to millions of veterans and their families while supporting more than a thousand healthcare facilities and clinics, as well as executing major IT modernizations and countless contracts.

Yet its legacy financial systems and fragmented supply chain tools, plus decentralized contracting oversight, fail to provide leaders with the necessary real-time communications and visibility into spending, inventory, and billing accuracy necessary for adequate monitoring. When payment processes, inventory controls, or budget checks break down—even briefly—the sheer volume of transactions can turn small errors into large losses, diverting funds from veteran care and eroding public trust.

In August 2024, VA disclosed a projected $15 billion funding shortfall, prompting heightened scrutiny of the department's financial forecasting and management capabilities. As further detailed below, the OIG found that improved financial management practices and greater accountability within VA would have reduced the risk of a reported shortfall. Further, improvements in consistency, financial oversight, reporting accuracy, and communication processes would have provided greater clarity and may have obviated the need for the funding requests to Congress at the end of the fiscal year.

Why This Is a Challenge

VA's legacy financial systems and unreliable data have hindered its ability to make informed decisions, prevent costly errors, provide leaders with a complete financial picture to prevent budget shortfalls, and assure Congress that appropriated funds are consistently used as intended. Legacy financial systems also are contributing causes to two of VA's three long-standing material weaknesses related to its financial statements—financial systems reporting and IT security controls. The other weakness is associated with accounting estimates. In addition, VA has had significant deficiencies for the past several years in the areas of home loan guaranty liability estimates, entity-level controls and obligations, undelivered orders, and accrued expenses.

Recent OIG reports have shown that deficient controls and lack of clarity of roles, responsibilities, and accountability over financial reporting impeded accurate budgetary forecasting. The FY 2024 $12 billion supplemental request from VHA (later revised down to $6.6 billion), and VBA's requested $2.9 billion supplement, were ultimately not needed. For VHA, this budgetary gap occurred because staff relied on outdated data and flawed assumptions, including lower-than-actual costs for new medications and both direct and community care projections, and an unanticipated legislative budget cap. VBA's underestimate occurred because leaders did not include realized prior-year recoveries in its monthly status report calculations throughout the year, which would have shown a reduced risk of a shortfall by year-end.

At the program level, defective IT tools and weak internal controls have compromised VA's ability to stop preventable monetary losses. For example, the Program Integrity Tool, a key system to detect duplicate payments and fraud for the community care program, was offline for nearly 17 months (from February 2023 to July 2024), and is still not fully restored. During that time, VA lost its single consolidated source for community care claim reviews as well as the ability to bill veterans and private insurers in a timely manner. It also hampered efforts to detect duplicate or fraudulent payments and to satisfy earlier OIG recommendations to shore up revenue operations and fraud-mitigation efforts. Pausing the Program Integrity Tool stalled billing for about 40 million community care claims, delayed the collection of $665.5 million in revenue, and caused staff to use manual work-arounds. Meanwhile, missing pass-through language from community care contracts and weak payment controls created vulnerabilities that resulted in third-party administrators billing VA for more than they paid dental providers, generating over $910 million in excess reimbursements and an estimated $108.9 million in outpatient overpayments.

The OIG continues to identify facility-level mismanagement of open obligations, purchase card violations, and discrepancies between what inventory is recorded and what is physically present. If these errors continue, VA's ability will be constrained to effectively budget for supplies, equipment, and medications that meet patient care needs. Inadequate financial oversight enterprise-wide has also resulted in some potential violations of the "bona fide needs" rule—an appropriation law mandating that a fiscal year's appropriation only be obligated to meet a legitimate need during that "period of availability."

Department's Corrective Actions

VA is taking action on OIG recommendations that focus on implementation of robust internal controls and oversight across all program areas to protect funds and make the most efficient use of taxpayer dollars. This includes enhancing the monitoring of third-party administrators in community care, improving inventory management, and ensuring proper use of purchase cards. VA has also taken steps to increase accountability in contracting and procurement processes to prevent unauthorized or wasteful spending, but this requires continuous improvements. For benefit programs, VA also has made progress on detecting and addressing fraud as well as waste to safeguard the integrity of these programs. OIG reports will continue to indicate where ongoing efforts should be focused.

To improve its financial accounting and reporting, VA has been incrementally rolling out the Integrated Financial and Management System (iFAMS) as part of the enterprise-wide modernization effort to replace legacy systems that facilitate the department's financial and contracting activities. The early waves of deployment have been designed to address identified problems before full implementation within VBA and VHA. While implementation of iFAMS VA-wide should help to address some of VA's financial reporting deficiencies, it is critical that stakeholders thoroughly test the system and address opportunities for improvement.

Further, to prevent future budget miscalculations, VA is taking steps to improve real-time surveillance over its budget while reviewing projection models. VA has also revised inputs for the Enrollee Health Care Projection Model to better account for community care growth, staffing, and pharmacy and prosthetic services. Taking these steps becomes especially important as community care expenditures continue to grow year over year.

With regards to the Program Integrity Tool, VA agreed with OIG's recommendations to focus on ensuring payments are only for authorized care, expanding its post-payment analytics, and tightening contracting officer oversight, particularly for overpayment recoupment processes.

Specifically, to further improve community care oversight, VHA restored the Program Integrity Tool's revenue collection functionality and is rebuilding its fraud-detection capabilities while upgrading servers and data logic. VHA is also inserting reimbursement caps and pass-through language into future Community Care Network contracts and expanding post-payment reviews.

As noted in OIG testimony, while the Program Integrity Tool returns to full functionality, VA will need to continue working on resolving the backlog of paid claims to identify and bill veterans for copayments. Veterans may be negatively affected because they could receive copayment bills for care delivered more than a year ago—although as of August 2025, VA was still working to implement a regulatory change that would allow it to seek waivers on behalf of veterans when debts are accrued due to the fault of the agency.

These refinements can enhance VA's credibility with the veteran community, congressional leaders, taxpayers, and other stakeholders. Additionally, by making these improvements, VA can better align its financial management practices with its mission of providing timely and reliable care and benefits to veterans and their families.

OIG Challenge #4: Information Systems and Innovation

In addition to the financial systems discussed in the prior section, VA leaders face challenges in optimizing other existing systems and incorporating emerging technology to store, manage, and maintain secure access to vast amounts of sensitive data as required. This includes veterans' medical records, benefits determinations, financial disclosures, and education documents.

VA has continued its drive to modernize an array of mission-critical platforms—electronic health records, acquisitions, antifraud analytics, cloud-based collaboration tools, and several benefits and appeals processing applications—all while trying to address decades-old cybersecurity and data-integrity gaps. These modernization projects are now estimated to cost tens of billions of dollars, and their success depends on tightly interlocking schedules and data flows, making implementation both costly and complex. However, the OIG has found that ambitious timelines for development and deployment often conflict with the department's ability to design, govern, secure, and fully stabilize those systems. The OIG recognizes the difficulty of this undertaking

and has recommended enhancements and measures to not only safeguard these systems and data but also ensure VA staff are supported as they work to implement these systems and navigate constant changes while continuing to maintain operations and implement programs and services.

Why This Is a Challenge

Information system failures have repeatedly caused breakdowns in key VA services and functions, including many previously mentioned on financial reporting, contracting, supply chain management, claims processing, appointment management, community care billing, and fraud detection. VA has historically struggled to effectively deploy new IT projects. In addition, OIG work has demonstrated these IT projects are often impeded by inadequate planning (including lack of a comprehensive master schedule), insufficient requirements development, not enough stakeholder engagement, failures to promptly fix known problems, and lapses in program management or coordination. These difficulties have led to cost overruns, extensive delays, lower user acceptance, and functionality gaps that make it difficult for VA personnel to do their jobs.

VA continues to face technical challenges with three large-scale IT implementation efforts, some mentioned in prior sections: the Electronic Health Record Modernization program, iFAMS, and Caseflow. The Electronic Health Record Modernization program experienced major performance incidents—360 outages, severe degradations, and functionality issues at its first five sites—which contributed to VA's decision to halt deployment at other planned sites. Inadequate controls for handling major performance incidents primarily occurred because of the way the original May 2018 contract was written. VA modified the contract in 2023 to strengthen some requirements, but additional OIG recommendations that address the process for assessing performance issues remain open. Continued major performance incidents can lead to further costly delays in system implementation and pose an ongoing risk to patient safety.

At the same time, iFAMS went live without end-to-end interface testing, resulting in errors that delayed the construction invoicing process and forced staff to find manual work-arounds for a year after it was deployed. Complications with iFAMS occurred because leaders did not adequately include acquisition stakeholders in decision-making roles to ensure the new acquisition functionality addressed concerns about its lack of automation and the length of time it took to perform various actions. Users also had concerns with the training provided for some iFAMS tasks and day-to-day activities.

Meanwhile, Caseflow—the end-to-end technology system VA adopted to support processing claims and appeals through tracking decisions for various stakeholders—lacked an enterprise-wide governance structure. As a result, Caseflow's functionality was limited, and its ability to report on a claim's status was inefficient. VA's Office of Information and Technology did not provide a road map for Caseflow's build-out and restricted key stakeholders' access to developers, making it difficult to implement key requirements.

As the healthcare section mentions, IT system failures have also affected patient care. OIG reports have detailed instances of clinicians being unaware of critically important patient data. Communication breakdowns between VA and community care providers have also led to delayed diagnoses and treatment of patients. While such communication challenges are not new, the dramatic increase of community care referrals has amplified the urgent need for resolution. Additionally, recent OIG reports have highlighted the inherent inefficiency of having staff use two recordkeeping systems to document and read patient information.

Congress passed the Federal Information Security Modernization Act of 2014 (FISMA) to strengthen existing federal information security programs and practices. VA continues to encounter significant barriers to meeting FISMA requirements including deficiencies in controls related to access, configuration management, and security management, as well as service continuity practices. OIG inspections and reports repeatedly highlight these security concerns, including one instance in which a system misconfiguration allowed any VA user to view sensitive human resources and taxpayer information, as well as protected veteran health information from anywhere in the nation. Another OIG report confirmed long-standing critical vulnerabilities including ineffective security management allowing personnel to bypass security protections, leaving about 3.3 million veterans' records unencrypted at one facility.

VA's challenges with updating and replacing IT systems are a persistent concern, with problems related to its information security program due in part to not keeping pace with changes. As the second largest federal agency, VA holds a vast amount of sensitive personal data from veterans, beneficiaries, personnel, and contractors. Strict controls are needed to protect this information. The inadequacies and identified ineffectiveness of VA's information security controls has continually been highlighted in the OIG's reports and congressional testimonies.

Department's Corrective Actions

VA has taken some action to continue tightening its IT systems controls and mitigate identified program deficiencies. In agreeing to implement OIG recommendations, VA has presented action plans to expand efforts to gain insights from systems users and other stakeholders to ensure improvements are made and new systems better meet their needs.

Regarding VA's ongoing electronic health records overhaul, VA strengthened the contractor agreement by enhancing performance credit clauses (provisions that establish financial penalties if the contractor fails to meet performance standards) and tighter incident metrics. It created limited real-time system dashboards to help monitor performance at sites going live with the system. However, there remain 32 OIG recommendations that are not fully implemented as VA resumes system deployments.

While VA has moved forward with iFAMS, the OIG has pressed VA to enhance the interface development procedures and work closely with leaders in the Office of Acquisition and Logistics to resolve ongoing user concerns before deploying the acquisition model to more sites.

Many VA information systems are interconnected, so changes or deployments in one can significantly impact the functionality of others. VA must also prioritize a sound IT security structure and effective controls over both existing and new systems to better detect unauthorized access and other vulnerabilities.

OIG Challenge #5: Leadership and Governance

Strong leadership and sound governance are critical to the success of any organization. For VA, fostering a culture of high reliability and accountability is especially critical given its mission, size, and the complexity of its portfolio. Improved governance can help VA better identify, prevent, and address threats to patient safety while making the most effective use of funds in supporting veterans and their families through its myriad operations, programs, and services. The OIG's work has spotlighted issues and deficiencies in accountability, often stemming from poor communication or confusion about roles and responsibilities for internal monitoring and approvals, which have led to serious consequences.

Why This Is a Challenge

Numerous OIG reports depict the consequences of ambiguous or unenforced policies contributing to ineffective or absent internal VA oversight and failure to quickly detect and address risk. When leaders do not set clear expectations, monitor execution, and hold staff accountable, patient safety, veterans' welfare, and VA resources are in jeopardy.

Thorough oversight is essential for identifying noncompliance with laws, regulations, policies, and procedures. However, the OIG has found that risks are often not detected before significant problems occur because of ineffective monitoring. For example, an OIG report found discrepancies between VISN direction, VHA policy, and other requirements that led to confusion about the rules surrounding surgical resident physicians and permitted trainees to work at VA medical facilities without direct supervision.

Inconsistent, absent, or unattainable performance benchmarks can also lead to adverse outcomes. Too frequently, VA's most vulnerable veterans—often unable to advocate for themselves—fall through the cracks in both healthcare delivery and fiduciary services. Continued acceptance of widespread failures in meeting community care and other benchmarks leave veterans waiting for appointments and exam results. Inconsistent guidance and oversight have resulted in veterans—including those unhoused—not receiving care management, crucial suicide assessments and safety plans, treatment plans, or assistance with transitions in care. Another recent OIG report identified the national oncology program's infrastructure and oversight to be incongruent with what VA identifies as fundamental to high-quality care.

Poor oversight has also resulted in credentialing and privileging program issues, permitting providers to render care without necessary privileges, verified competencies, or remediation after

performance deficiencies were identified. In one report, a provider who was neither credentialed nor privileged was assigned to provide care in an intensive care unit. Poor oversight also permitted improper quality management processes, leaving risks unidentified and unresolved.

Many of the shortfalls described in OIG reports could have been prevented if warning signs were detected and acted on by engaged leaders or empowered staff. Several inspections have found a lack of accountability, resulting in ongoing deficiencies in patient care and operations. Other inspections encountered staff who reported feeling unsupported and untrusting of leaders, which hindered the open communication and collaboration necessary to identify and remedy adverse events. One OIG report documented a facility chief of staff who did not fully review and address patient safety reports and concerns, a failing echoed in other facilities as well. Several OIG reports identified facility noncompliance with VA's policy on disclosing adverse events. Not acknowledging the impact of adverse events through candid conversations with patients and their families jeopardizes trust between VA and patients as well as deprives patients of information regarding their rights and potential remedies.

Weak governance also hampers supply chain management. An OIG review found that while VISN supply chiefs completed the required quality control reviews, facilities did not comply with policy for more than 18 percent of the areas under review. Further, deficiencies remained unresolved from the previous year's quality control reviews because staffing vacancies ran high, VISN supply chiefs did not always identify or report noncompliance at their facilities, and action-plan-tracking spreadsheets could be overwritten. Other recent OIG reports found that facilities purchased nonexpendable medical equipment without following required processes or necessary approvals because facility staff interpreted guidance differently. Another report found that VHA medical facilities could not account for some equipment items, while other items were in locations that differed from what was listed in the inventory system. In some cases, equipment was sitting in facilities unused.

Collectively, these lapses illustrate how diffuse oversight and unclear lines of authority can risk patient safety, waste funds, and allow equipment to be lost and environmental hazards to linger.

Department's Corrective Actions

Across VA, leaders took action in response to OIG recommendations aimed at improving governance, internal oversight, and monitoring. For example, to strengthen staff incentives monitoring, human resource officials have begun building risk-based quality-control procedures and annual incentive payment audits. Additionally, the Procurement and Logistics Office is piloting an automated dashboard to replace manual spreadsheets used for quality reviews that are at risk of being overwritten and has agreed to track supply chain vacancies and flag facilities that need network-level intervention.

VA has submitted action plans that include updating physical inventory requirements, assessing compliance through periodic reviews, and monitoring and addressing gaps identified through

supply chain metrics and reports. Adoption of a standardized "report of survey" dashboard will allow VA to centrally report lost, stolen, or damaged items and regularly monitor facility inventory compliance and take needed action. Further, VA is taking steps to fully implement the equipment planning and approval process, while developing a system to ensure that facility staff are following process and approval requirements before purchasing.

It is essential to establish clear policies that standardize processes for all facilities and create guardrails, while still allowing leaders to exercise flexibility and discretion when necessary. To prevent recurring findings across VA, leaders should seek out and apply lessons learned regarding vulnerabilities and deficiencies identified through a combination of internal reviews and OIG reports. Additionally, VA should take prompt action on the OIG's open recommendations and identify solutions that address the root causes discussed. Although recommendations may be issued to a particular facility or office, OIG suggests the information provided should be considered across the department.

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 following table.

Appendix: Related Reports and Congressional Testimony

The reports and congressional testimony listed below support the OIG's identification of VA's FY 2025 major management challenges. All OIG publications are available at www.vaoig.gov/.

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Better Controls Needed to Accurately Determine Decisions for Veterans' Nonpresumptive Conditions Involving Toxic Exposure Under the PACT Act	9/30/2025		X			
Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens	9/30/2025	X				X
Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes	9/11/2025	X				X
Improved Oversight of VHA's Nonexpendable Equipment Is Needed	9/4/2025			X		X
Facilities Need to Fully Implement VHA's Strategic Planning and Request Process for Nonexpendable Medical Equipment	9/4/2025			X		X
VISN 12 Needs to Improve How It Administers the Veteran Community Care Program	8/27/2025	X				
Inconsistent Implementation of VHA Oncology Program Requirements due to Insufficient Oversight	8/14/2025	X				X
VA Can Strengthen Appeals Processing and Tracking by Improving Caseflow Program Management	8/13/2025				X	
Fiscal Year 2025 Occupational Staffing Report	8/12/2025	X				
Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas	8/6/2025	X				X
Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA	7/31/2025	X				X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Western New York Healthcare System in Buffalo						
Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque	7/31/2025	X				X
Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore	7/16/2025	X				X
Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota	7/2/2025	X				
Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania	6/26/2025	X				X
Mental Health Inspection of the VA Salem Healthcare System in Virginia	6/26/2025	X				X
Federal Information Security Modernization Act Audit for Fiscal Year 2024	6/18/2025				X	
Recruitment, Relocation, and Retention Incentives for VHA Positions Need Improved Oversight	6/12/2025			X		X
Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia	6/12/2025	X				X
Healthcare Facility Inspection of the VA St. Louis Healthcare System in Missouri	6/10/2025	X				X
VBA's Special Monthly Compensation Calculator in the Veterans Benefits Management System for Rating Did Not Always Produce Accurate Results	5/29/2025		X			
Better Communication and Oversight Could Improve How the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program Manages Funds	5/28/2025			X		X
Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia	5/22/2025	X				X
Deficiencies in Emergency Care for a Female Veteran at Martinsburg VA Medical Center in West Virginia	5/21/2025	X				

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Inspection of Information Security at the Battle Creek Healthcare System in Michigan	5/1/2025				X	
Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana	4/24/2025					X
Integrated Financial and Acquisition Management System Interface Development Process Needs Improvement	4/24/2025				X	
Improper Sharing of Sensitive Information on Cloud-Based Collaborative Applications	4/22/2025				X	
Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth	4/17/2025	X			X	
The PACT Act Has Complicated Determining When Veterans' Benefits Payments Should Take Effect	4/15/2025		X			
Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction	4/10/2025	X				X
Healthcare Facility Inspection of Memphis Healthcare System in Tennessee	4/1/2025	X				X
Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities	3/31/2025					X
Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments	3/27/2025		X	X		
The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request	3/27/2025	X		X		
Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia	3/26/2025	X				X
Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers	3/20/2025	X				

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022	3/19/2025	X				
Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight	3/19/2025	X				
Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas	3/18/2025			X		
Healthcare Facility Inspection of Washington DC Healthcare System	3/13/2025	X				X
Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia	3/6/2025	X				X
Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	3/5/2025	X				X
Healthcare Inspection VISN Summary Report: Evaluation of Practitioner Credentialing and Privileging for Fiscal Years 2023 to 2024	2/25/2025	X				X
Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services	2/20/2025			X		
Financial Efficiency Inspection of the VA Tampa Healthcare System	2/13/2025			X		
Deficiencies in Invasive Procedure Complexity Infrastructure, Surgical Resident Supervision, Information Security, and Leaders' Response at the Lieutenant Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan	2/4/2025	X				X
Deficiencies in Case Management and Access to Care for HUD-VASH Veterans at the VA Greater Los Angeles Healthcare System in California	1/30/2025	X				X
Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona	1/23/2025	X				X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers	1/22/2025	X				
Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers	1/16/2025	X				
VBA Provided Accurate Training on Processing PACT Act Claims but Did Not Fully Evaluate Its Effectiveness	1/15/2025		X			
Healthcare Facility Inspection of the VA Poplar Bluff Health Care System in Missouri	1/15/2025	X				
Inspection of Pacific District 5 Vet Center Operations	1/8/2025	X			X	
Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama	12/19/2024	X				X
Improvement in the Patient Safety Program with Continued Opportunities to Strengthen Veterans Integrated Service Network 7 Oversight at the Tuscaloosa VA Medical Center in Alabama	12/19/2024	X				X
Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies	12/18/2024	X				X
Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination	12/18/2024	X				X
Audit of VA's Financial Statements for Fiscal Years 2024 and 2023	12/10/2024			X		
Survivors Did Not Always Receive Accurate Retroactive Benefits for Dependency and Indemnity Compensation Claims Reopened Under the PACT Act	12/3/2024		X			
Staff Incorrectly Processed Claims When Denying Veterans' Benefits for Presumptive Disabilities Under the PACT Act	12/3/2024		X			
Veterans Health Administration Initiated Toxic Exposure Screening as Required by the Promise to Address Comprehensive Toxics (PACT) Act but	11/14/2024	X				X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Improvements Needed in the Training Process						
Inspection of Information Security at the Health Eligibility Center in Atlanta, Georgia	11/13/2024				X	
Heart Transplant Program Review: Facility Leaders Failed to Ensure a Culture of Safety and the Section Chief Engaged in Unprofessional Conduct at the Richmond VA Medical Center in Virginia	10/24/2024	X				X

Congressional Testimony	Date	Challenge				
		#1	#2	#3	#4	#5
Hearing on Pending Legislation	6/11/2025			X		
Waste & Delays: Examining VA's Improper Payments in its Compensation and Pension Programs	5/14/2025		X			
Answering The Call: Examining VA's Mental Health Policies	4/30/2025	X				X
From Reset to Rollout: Can the VA EHRM Program Finally Deliver?	2/24/2025			X	X	
Roles and Responsibilities: Evaluating VA Community Care	2/12/2025	X				
VA First, Veteran Second: The Biden/Harris Legacy	2/6/2025	X				
VA Cybersecurity: Protecting Veteran Data from Evolving Threats	11/20/2024				X	