



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE  
SUBCOMMITTEE ON HEALTH  
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS  
HEARING ON  
LESSONS LEARNED? BUILDING A CULTURE OF PATIENT SAFETY WITHIN THE VETERANS  
HEALTH ADMINISTRATION  
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Chairwoman Brownley, Ranking Member Bergman, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the Department of Veterans Affairs' Veterans Health Administration (VHA). The OIG's Office of Healthcare Inspections reviews the quality and safety of health care provided across VHA and communicates the findings through a variety of public reports, including hotline inspections, national reviews, comprehensive healthcare inspections, Vet Center inspections, and Veterans Integrated Service Network (VISN) reviews. For each of these reports, the OIG clinical review teams provide recommendations for improving processes or further reducing risks to the veterans who entrust their health care to VHA. These multifocal oversight products evidence that despite employing hundreds of thousands of qualified and dedicated clinical and support staff, leaders across various levels of VHA do not consistently ensure the safety of the veterans they serve.

Healthcare facilities committed to patient safety routinely follow protocols that prioritize high quality care. They have a structured and proactive quality and safety management oversight team. They exercise a shared responsibility among individuals involved in patient care to recognize and report any perceived compromises to the safety of every patient at every interaction. Patient safety is "the culture," and the leaders at such facilities are constantly engaged in promoting that culture through their interactions with staff at all levels. That culture is demonstrated in leaders' communications with stakeholders and the innovative use of quality metrics that not only assess the state of patient safety, but also evaluate and act on concerning trends. Ensuring patient safety must be a continuous activity that fuels every interaction with those receiving care.

The OIG's oversight work repeatedly reveals the efforts of highly qualified and dedicated staff committed to providing patients with the care they need, regardless of the obstacles. A hallmark

example of such dedication was demonstrated at the Washington DC VA Medical Center where staff went to great lengths to make sure medical supplies and equipment were in patient care areas when needed in order to work around a broken supply management system.<sup>1</sup> Sadly, even heroic frontline efforts cannot ensure the safety of every veteran, which is why patient safety efforts need to permeate every aspect of VHA care and monitoring.

Recent OIG reports continue to highlight catastrophic breakdowns in patient safety practices that have compromised care and even contributed to the deaths of veterans. For example, Dr. Robert M. Levy, the former pathologist at the VA Health Care System of the Ozarks in Fayetteville, Arkansas, was found to have misdiagnosed thousands of patients' pathological specimens, adversely affecting the diagnosis and clinical management of these veterans. In addition, in his position as chief of pathology, he was able to alter quality management documents to conceal his errors.<sup>2</sup> He was sentenced to 20 years in federal prison, followed by three years of supervised release, and ordered to pay \$497,745 in restitution for one count each of mail fraud and involuntary manslaughter.<sup>3</sup> In another example, former VA nursing assistant Reta Mays pleaded guilty to seven counts of second-degree murder and one count of assault with intent to commit murder in the deaths of eight patients at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.<sup>4</sup> She was entrusted with providing compassionate and supportive care to patients, but she administered insulin to them with the intent to cause their deaths. Her activities went undetected for so long, in part, because of failures in reporting and sharing suspicions among clinical staff involved in the victims' care.<sup>5</sup>

While VHA has been at the forefront of many initiatives to prevent patient harm, it has “lacked a coordinated, enterprise-wide effort.”<sup>6</sup> In February 2019, VHA rolled out a new initiative through its Office of Healthcare Transformation outlining definitive steps toward becoming a high reliability organization. These organizations are grounded by a basic tenet, the Just Culture. Within a just culture, personnel at every layer of a system understand and react to not just identifiable risks and errors, but any vulnerabilities that could lead to patient harm. As with any system-wide initiative, the rollout and critical staff buy-in are ultimately dependent on the commitment and engagement of leaders. Importantly, a just culture ensures accountability for all errors, near misses, and perceived risks. Leaders that promote such

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<sup>1</sup> [Critical Deficiencies at the Washington DC VA Medical Center](#), March 7, 2018.

<sup>2</sup> [Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas](#), June 2, 2021.

<sup>3</sup> United States Department of Justice, [Fayetteville Doctor Sentenced To 20 Years In Federal Prison For Mail Fraud And Involuntary Manslaughter](#), January 22, 2021.

<sup>4</sup> United States Department of Justice, [Former VA Hospital Nursing Assistant Admits to Murdering Seven Veterans and Assault with Intent to Commit Murder of an Eighth](#), June 14, 2020.

<sup>5</sup> [Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia](#), May 11, 2021.

<sup>6</sup> VHA High Reliability Organization Reference Guide, March 31, 2021.

accountability and react with transparency and fairness to their staff's misconduct and missteps help establish a culture in which staff feel not only responsible for, but also safe, reporting all concerns.

The causes of patient safety breakdowns within VHA that the OIG has identified are often multifactorial, and in extreme cases, criminal. In most instances, opportunities were missed at many levels to intervene and protect patients. Understanding the origins of these missed opportunities is critical. OIG oversight work has shown that these missed opportunities were nearly always due in large part to the actions, and even more often *inactions*, of leaders.

### **LEADERS MUST CREATE AN ENVIRONMENT WHERE SPEAKING UP FEELS SAFE AND PRODUCTIVE FOR ALL STAFF**

Facility leaders cannot witness every interaction with the patients their staff serve, but they can create an environment where every staff member has a clear understanding of their role in protecting patients. Too often, even when observed behaviors may be criminal, OIG inspections revealed opportunities where staff at many levels *could have* intervened, but felt scared, helpless, voiceless, or useless in reporting up concerns. In Fayetteville, Arkansas, the OIG found a culture in which staff did not report serious concerns about Dr. Levy, in part because of a perception that others had reported them, or they were concerned about reprisal. Facility leaders' failure to robustly explore or take actions after reports of Dr. Levy's impaired behavior and the subsequent events may have discouraged staff from continued efforts to comply with the facility's policy to report observations of misconduct.

In yet another instance, at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, the OIG found that the then chief of surgery's words and behavior towards staff contributed to a fearful and retaliatory environment that may have led to underreporting of quality-of-care concerns and promoted a perception that surgical quality data were being manipulated in the surgeon's favor.<sup>7</sup>

### **LEADERS MUST IMMEDIATELY REVIEW AND CORRECT ISSUES THAT COMPROMISE THE SAFETY OF PATIENTS**

When errors or compromises to patient safety are brought forward, corrective actions must be immediate. Leaders should conduct a timely review of concerns and implement a thoughtful plan to redress them. Communicating prompt and meaningful responses are important not only to protecting patients, but to building trust and engaging staff as partners in patient safety. The OIG has frequently reported on occasions in which facility leaders failed to promptly address patient care issues. For example, a provider in the Danville community-based outpatient clinic of the Salem VA Medical Center in Virginia documented identical blood pressure readings at an unlikely frequency—many for patients with prior high blood pressure readings. The OIG team determined that the provider had falsified blood

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<sup>7</sup> [Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida](#), January 13, 2021. The same surgeon was the subject of a prior OIG report, [Healthcare Inspection – Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System, Bay Pines, Florida](#), August 16, 2017.

pressure readings for hypertensive patients in an apparent attempt to avoid providing appropriate follow-up and management that would have been triggered by higher numbers.<sup>8</sup> Despite facility leaders being immediately informed of the preliminary findings that patients could be at risk for serious complications of untreated hypertension, it was not until the OIG team made a follow-up call to the facility’s chief of staff eight weeks later that the facility began an in-depth review of the care provider’s practices. The provider was ultimately fired.

Similarly, a patient went to the Washington DC VA Medical Center’s emergency department for suicidal ideation, and the OIG substantiated that an emergency department physician made a statement to the effect that “[the patient] can go shoot [themselves]. I do not care” as the patient was leaving the facility.<sup>9</sup> While the OIG could not substantiate the patient heard the statement, the patient died by suicide six days later. Although leaders were long aware of this physician’s prior pattern of verbal misconduct toward VA staff, and despite staff reporting the physician’s statement to superiors, leaders did not pursue formal administrative reviews related to the physician’s behavior. It took the involvement and persistence of OIG staff to ensure that leaders discontinued the physician’s contract and reported the physician to the state licensing board and National Practitioner Data Bank.

Among other examples of this problem, the OIG assessed the circumstances around a patient’s suicide following delayed cancer treatment. The team found deficiencies in the quality management process at a medical facility in VISN 15, evidenced by facility leaders’ failing to initiate a retrospective fact-finding or administrative investigation board that could identify the causes and corrective actions.<sup>10</sup> The internal delay was so significant that the institutional disclosure to the next of kin had not been completed even months after the patient’s death.

## **LEADERS MUST HOLD THEMSELVES AND THEIR STAFF ACCOUNTABLE WHEN PATIENT SAFETY IS COMPROMISED**

The framework for a high reliability organization is the just culture described earlier. Unfortunately, the OIG continues to find leaders avoiding accountability or not holding their staff responsible for behaviors that compromised patient safety. In one report, the OIG found that a Veterans Crisis Line (VCL) responder’s neglect of duty in managing a call contributed to failing to prevent the caller from killing a family member. VCL leaders took steps to improve the responder’s job performance but did not fully investigate the misconduct or consider an administrative investigation board—citing an uncertainty about the authority of VCL leaders to initiate the process, an authority which in fact they had.

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<sup>8</sup> [\*Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia\*](#), January 29, 2019.

<sup>9</sup> [\*Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center\*](#), July 28, 2020.

<sup>10</sup> [\*Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility\*](#), June 26, 2019.

As another example, at the Charlie Norwood VA Medical Center in Augusta, Georgia, the OIG found the staff's failure to properly implement restraint orders and consistently document observations led to a patient being in restraints for 71 hours and contributed to the patient's death.<sup>11</sup> Facility leaders' root cause analysis was not initiated until approximately two months after the patient's death (when the OIG team was on-site). Even after the facility's analysis was completed, the OIG identified significant gaps in the facility's review of the patient's care, including recognition that the patient remained in restraints for approximately 22 hours without a provider's order.

## **LEADERS MUST ASSERTIVELY SHARE CRITICAL INFORMATION AND LESSONS LEARNED**

Lessons learned related to patient safety at one facility can translate into lives saved at another. In a large, decentralized healthcare system such as VHA's, information sharing is critical, and it must be multidirectional. Every OIG report can serve as a roadmap for other VISN and facility leaders in identifying whether similar problems and corrective actions could be found or applied in their own medical facilities.

Reporting and sharing information is also critical to ensuring patient safety within VHA and potentially the community. Following the death by suicide of a patient recently discharged from the Columbia VA medical center in Missouri, the OIG identified care coordination and discharge planning deficiencies. These included inpatient mental health staff's failure to coordinate the patient's treatment or include local Vet Center staff in the discharge planning.<sup>12</sup> The OIG found that facility, VISN, and National Center for Patient Safety leaders also did not have knowledge of a 2017 memorandum of understanding between the Office of Mental Health and Suicide Prevention and Rehabilitation Counseling Services (the entity that manages Vet Centers), which required Vet Center representation for shared patients during VHA root cause analyses.

Non-VA oversight and licensing officials must also be notified when patient safety is at risk. At the Biloxi VA Medical Center in Mississippi, the OIG found that facility leaders did not report a provider's inappropriate behaviors and language during gynecologic exams (such as vulgar and offensive comments) to either state licensing boards or the National Practitioner Data Bank despite evidence that the provider's conduct may have met the reporting standards.<sup>13</sup> The facility's director told the OIG team that he was aware of some complaints regarding the subject gynecologist, but that the chief of staff was responsible for investigating complaints about care providers that would support a state licensing board

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<sup>11</sup> [\*Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia\*](#), September 30, 2020.

<sup>12</sup> [\*Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri\*](#), January 5, 2021.

<sup>13</sup> [\*Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi\*](#), February 10, 2021.

review. The chief of surgery explained that not reporting the subject gynecologist's behavior on the State Licensing Board Provider Exit Review form was "a mistake on my part as a manager." Failure to report can allow practitioners' misconduct to continue and go undetected if the provider moves to another healthcare system.

## **LEADERS MUST SET THE TONE FOR A CULTURAL TRANSFORMATION**

A successful transformation is not a defensive exercise. Errors and near misses will happen, but the frequency can be reduced when leaders are proactive in planning for how to address them. When problems do occur, they should acknowledge the facts, study the context, and engage appropriate experts to develop action plans to mitigate further risk. Leaders must set a tone by using every identified *missed* opportunity in protecting a patient's safety as a *learning* opportunity for staff across the system. The quality and impact of OIG oversight work is enhanced when facility, VISN, and VHA leaders provide *prompt* feedback, technical comments, and thoughtful action plans.

One recent report detailed a clinical teams' mismanagement of a patient experiencing alcohol withdrawal at the Tomah VA Medical Center in Wisconsin.<sup>14</sup> The OIG identified multiple concerns related to this patient's diagnostic evaluation and admission that contributed to his death, which occurred after his transfer to a non-VA facility. Despite concurring with the recommendations, facility and VISN leaders, and VA's General Counsel, each submitted comments to include in the publication stating that the OIG did not describe the "excellent care the Tomah facility provided to the patient for eleven years prior to these tragic events," or the care the patient received at other non-VA facilities. Those comments do not advance a culture of safety in which accountability for errors and corrective actions are prioritized over deflection and defensiveness. The focus of the OIG report was the inadequate management of the patient's alcohol withdrawal and the patient's cardiac arrest at the facility that contributed to the patient's poor outcome and subsequent death.

Similarly, facility leaders provided dissenting remarks and submitted responses that deflected the serious concerns addressed in a report about a community living center patient who eloped from the Chillicothe VA Medical Center in Ohio.<sup>15</sup> The patient was subsequently struck and killed by a vehicle. The report described findings regarding an inappropriate admission based on the patient's needs, inadequate interventions to mitigate the patient's elopement, and clear failures in responding to the recognition that the patient was missing.

In response to a report that highlighted the mismanagement of mental health care for a patient at the Charleston VA medical center in South Carolina who subsequently died by suicide, and a second report that identified failures in addressing this same patient's reported intimate partner violence, VISN and

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<sup>14</sup> [Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin](#), August 26, 2021.

<sup>15</sup> [Deficiencies in Community Living Center Practices and Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio](#), May 6, 2021.

facility leaders insisted that staff met “the full intent” of VHA policies and initiatives in place at the time.<sup>16</sup> Facility leaders interpreted VHA and facility policy as replacing clinical judgement for high-risk patients. The OIG believes leaders should have acknowledged the deficiencies that were not in dispute and used the report’s recommendations as an opportunity to help staff in enhancing clinical decision-making processes and improving outcomes. Of particular concern was that leaders did not promote an evidence-based approach to risk assessment and mitigation as reflected in a leader’s suggestion that staff could not take every emergency department patient’s expressed homicidal thoughts “seriously.” When the highest levels in VA’s leadership yield to a defensive posture, the same can be expected from the people they lead.

### **LEADERS NEED TIME IN THEIR ROLES TO LEAD A SUCCESSFUL TRANSFORMATION**

According to the Joint Commission, effective hospital performance depends on how well leaders work together, integrate different skills, and consider varied leadership perspectives.<sup>17</sup> Building a strong leadership team understandably requires time. The OIG’s Comprehensive Healthcare Inspection Program (CHIP) has focused on leadership stability at medical centers and the VISNs for several years. While not appropriate to directly correlate the number and severity of the OIG’s critical findings from these inspection reports with the number of leadership vacancies or leadership team tenure together, the OIG believes that strong leaders are needed for a successful cultural transformation.

In the course of conducting fiscal year 2020 CHIPs, the OIG found that nearly half of the leaders interviewed at the 36 inspected VA medical centers had an overall tenure of two years or less. These permanent leaders may not have yet fully understood the landscape of their assignment and needed to gain the skills to navigate the constant challenges of leading people and change at their medical center. Also, less than 20 percent of the interviewed leaders had over five years in their positions.

Moreover, in a July 2021 VISN inspection, the OIG reported that the VISN 10 leadership team had served together in their roles for only three months, with various members joining since 2019.<sup>18</sup> The OIG identified potential risks at VISN 10 facilities, extended wait times for appointments, and evidence that VISN leaders needed to increase oversight of facility-level quality, safety, and value.

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<sup>16</sup> [Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center in Charleston, South Carolina](#), August 3, 2021; [Deficiencies in the Management of a Patient’s Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina](#), August 3, 2021.

<sup>17</sup> VHA High Reliability Organization Reference Guide, March 31, 2021.

<sup>18</sup> [Comprehensive Healthcare Inspection of Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati](#), July 1, 2021.

## **LEADERS MAY REQUIRE ADDITIONAL SUPPORT TO ENSURE PATIENT SAFETY**

While patient safety challenges all hospital systems regardless of complexity or size, OIG reports have identified distinct concerns at VHA's smaller, more rural, or less complex facilities. With limited community resources, these facility leaders often experience obstacles to delivering acute and urgent care as well as highly specialized care. Such barriers can pose significant risk to the patients they serve even beyond ensuring timely access to that care. Hiring decisions can introduce risk when the pool of specialty providers is limited, and if local leaders are not qualified to thoroughly evaluate the skill and expertise of applicants. Evaluating the quality of practice of specialty care providers already on staff can also overwhelm clinical leaders at these facilities, particularly when local and regional VA facilities do not have the specialty-matched support to review or adjudicate quality-of-care concerns.

In December 2018, the OIG became aware of allegations of patient safety risks at a VISN 10 medical facility.<sup>19</sup> A complainant alleged an ophthalmologist lacked training, provided substandard care, and failed to meet productivity expectations, all of which were substantiated in the report. Despite leaders being aware of these concerns, the facility's chief of staff intended to reappoint the surgeon following the probationary period. Facility staff told the OIG that they believed the surgeon would be reappointed because facility leaders needed the services of the surgeon's spouse, who was also a surgeon, and facility leaders described them as a "package set," admitting that relationship was a consideration. As a result, patients were placed at unnecessary risk for potential surgical complications for two years prior to the surgeon's termination.

As discussed earlier, at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, the OIG evaluated allegations related to a thoracic surgeon's complications, including patient deaths. Facility and VISN leaders engaged local and regional VHA subject matter experts, and consulted with external subject matter experts, to review the practice of the subject thoracic surgeon. While leaders wanted to provide their patients with specialty surgical services, they were unable to opine on or adjudicate complex specialty care quality concerns.

The OIG believes these and other publications support the appointment of centralized specialized clinical leaders in VHA to support local leaders in more complex decisions and reviews where on-site or regional expertise is not readily available.

## **CONCLUSION**

This Subcommittee and VA have made it a priority to improve the quality of health care delivered by VHA. OIG leaders and staff share your sense of urgency in addressing the issues that repeatedly compromise patient safety. Changes to VHA patient safety approaches are necessary and overdue, but impossible without the dedication of strong leaders who recognize that a cultural transformation is

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<sup>19</sup> [\*Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility\*](#), September 24, 2019.

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required to support meaningful and sustainable change. VHA's high reliability organization initiative, grounded in principles that can reduce risk and improve quality of care when consistently practiced, will hopefully guide VHA leaders and all staff towards a patient-first and veteran-centric culture.

In closing, the OIG has found the vast majority of VHA staff are dedicated and committed to providing high quality care. The stories of over 300,000 staff at 141 medical centers, 1,200-plus community-based outpatient clinics, and 300 Vet Centers are more often than not stories of how they continue to provide high quality and compassionate care to approximately seven million of our nation's veterans. OIG staff and leaders extend their gratitude for the level of participation and cooperation VHA personnel provide to oversight efforts, even while navigating the complexities of providing quality health care during a global pandemic. The OIG will continue to provide recommendations to further support their work and enhance VHA's mission.

Chairwoman Brownley and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

## APPENDIX: A SELECTION OF RELATED OIG PUBLICATIONS FROM 2019 TO 2021

1. [Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia](#), July 11, 2019.
2. [Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia](#), September 26, 2019.
3. [Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut](#), November 20, 2019.
4. [Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System, Dallas, Texas](#), January 23, 2020.
5. [Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia](#), May 12, 2020.
6. [Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center in North Carolina](#), May 19, 2020.
7. [Deficiencies in Virtual Pharmacy Services in the Care of a Patient](#), June 18, 2020.
8. [Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Health Care System in Pennsylvania](#), July 1, 2020.
9. [Anesthesia Provider Practice Concerns at the W. G. \(Bill\) Hefner VA Medical Center in Salisbury, North Carolina](#), July 2, 2020.
10. [Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia](#), December 16, 2020.
11. [Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison](#), April 15, 2021.
12. [Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia](#), July 1, 2021.
13. [Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque](#), July 8, 2021.
14. [Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas](#), July 15, 2021.
15. [Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations](#), August 5, 2021.

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16. [\*Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California\*](#), August 24, 2021.
  17. [\*Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina\*](#), August 24, 2021
  18. [\*Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama\*](#), September 15, 2021.
  19. [\*Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina\*](#), September 27, 2021.
  20. [\*OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2021\*](#), September 28, 2021.