



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
BUILDING AN ACCOUNTABLE VA:
APPLYING LESSONS LEARNED TO DRIVE FUTURE SUCCESS
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Chairman Bost, Ranking Member Takano, and Committee Members, thank you for the opportunity to discuss how the Office of Inspector General's (OIG) work enhances VA's accountability and continuous improvement efforts for its services, programs, and operations. The OIG's mission is to serve veterans and the public by conducting meaningful independent oversight of VA. Our more than 1,100 staff conduct and support accurate, fair, and impactful audits, reviews, healthcare inspections, and investigations across the nation. In just this past fiscal year, the OIG produced 250 oversight publications with 894 recommendations for corrective action. Our personnel have made over 200 arrests, fielded more than 36,000 contacts to our hotline, and testified before congressional committees on 14 occasions, including 10 before this committee or its subcommittees. Our work has resulted in a monetary impact of more than \$4.5 billion for VA. This would not be possible without the funding and other support we receive from Congress.

The OIG appreciates the work VA does every day on behalf of veterans. Secretary McDonough, other VA leaders, and the vast majority of personnel with whom the OIG staff engages recognize the benefits of meaningful, independent oversight and have been very responsive to our requests for information. We also value the regular interactions we have with senior leaders to understand their concerns and priorities. In addition, we have a strong and collaborative relationship with Comptroller General Dodaro and his staff, and our work often complements and builds on their oversight.

FOUNDATIONS OF ACCOUNTABILITY

The OIG's oversight reports reveal recurring themes and deficiencies that often center around key elements of accountability. They are routinely shared with VA leaders across the enterprise to encourage positive change and efficiencies within their respective programs and operations. OIG recommendations that focus on even a single medical facility or benefits process are often a road map for other facilities

and offices across VA to help prevent or correct similar problems that have gone undetected or unaddressed.

The OIG's work often focuses on five components of accountability:

1. Strong governance and clarity of roles and responsibilities
2. Adequate and qualified staffing to carry out those duties
3. Updated information technology (IT) systems and effectual business processes to support quality healthcare delivery, accurate and timely benefits, and efficient operations
4. Effective quality assurance and monitoring to detect and resolve issues
5. Stable leadership that fosters responsibility for actions and continuous improvement

The OIG reports referenced below help illustrate how weaknesses in any of these areas of accountability can negatively affect veterans, their families, and caregivers and can waste or misuse taxpayer dollars.

Strong Governance and Clarity of Roles and Responsibilities

Misconduct, failures to take appropriate action, and persistent problems are often the result of VA personnel or contractors not understanding their roles and responsibilities. In other cases, they understand their duties, but simply do not or cannot fulfill them. This may be due to outdated policies and procedures, conflicting guidance, or a lack of clear decision-making—often with those best positioned to act lacking the authority to do so.

Some oversight reports reveal the tension between program offices that may have the policy and oversight functions but lack the authority to direct staff in the field. OIG reports have noted this, for example, in the governance structure for VA police.¹ An OIG audit conducted in response to concerns about accountability found VA did not have adequate and coordinated governance over its police program, due in part to confusion about police program roles and authority and lack of centralized management. Governance of the police program has been divided between the Veterans Health Administration (VHA), whose medical facility directors directly supervise police assigned to their facilities, and the Office of Security and Law Enforcement (OSLE) that oversees police policy and inspections. In this structure, OSLE had the authority to inspect medical facility police programs but no authority to ensure the problems they detected were promptly fixed.

An OIG healthcare inspection described concerns with the oversight and supervision structure for military sexual trauma (MST) coordinators.² The VHA Office of Mental Health and Suicide Prevention oversaw and provided funding for the national MST Support Team that was tasked with facilitating communications among regional staff, MST coordinators, and other VA staff. Yet funding for MST

¹ VA OIG, [Inadequate Governance of the VA Police Program at Medical Facilities](#), December 13, 2018; VA OIG, [VA Police Information Management System Needs Improvement](#), June 17, 2020.

² VA OIG, [Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations](#), August 5, 2021.

programs at the facility level was allocated by facility leaders, resulting in MST coordinators having to compete against other medical facility needs for support. The OIG found that inadequately protected administrative time, insufficient support staff, and deficient funding were among the problems that challenged MST coordinators' ability to fulfill their responsibilities to patients. The OIG made one recommendation to the under secretary for health to evaluate the guidance and operational status and take necessary actions.

A review of the Intimate Partner Violence Assistance Program (IPVAP) revealed personnel at both the Veterans Integrated Services Network (VISN) and facility levels were confused about their roles and responsibilities, impeding the progress of this program.³ In interviews, VISN champions expressed the need to clarify their responsibilities and those of VISN lead coordinators. Almost half of the IPVAP facility coordinators described inadequate resources to fulfill their responsibilities. Fourteen percent of IPVAP facility coordinators reported that their facilities did not implement routine screening to help detect and offer services and supports to patients who might be subjected to intimate partner violence. Although IPVAP facility coordinators are identified as responsible for program evaluation, the OIG found that VHA had not established standardized program evaluation methods or measures.

Confusion over roles and decision-making that is not fully informed can affect patient care and business operations on even the most routine operations. The OIG review on the cause of a backlog of mail at the Atlanta VA Health Care System (HCS) in Decatur, Georgia, revealed that the HCS and VHA's Payment Operations and Management (POM) office mismanaged incoming mail from November 2020 to September 2021, causing a backlog of more than 17,000 mailed items.⁴ The mail included veterans' medical records, claims for payment from veterans and community care providers, and checks totaling nearly \$207,000. The cause was traced to a verbal agreement that transferred POM's responsibility for mail management to HCS personnel, without engaging HCS staff expected to take on this work. HCS leaders lacked a clear understanding of the additional workload they assumed and did not ensure enough staff were adequately prepared for managing the influx of mail. POM officials were later reluctant to help, citing the transfer of their responsibilities in a verbal agreement. VA concurred with the OIG's five recommendations, including one recommendation focused on addressing all negative consequences, but that recommendation remains open.

Similarly, OIG reports on Veterans Benefits Administration (VBA) claims-processing deficiencies identified the tension and disconnect between VBA's Office of Field Operations (OFO) and Compensation Service office. OFO manages the employees who process veterans' claims, sets

³ VA OIG, [Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance](#), September 28, 2022. VA has divided the country into 18 regional systems of care referred to as Veterans Integrated Services Networks. See www.va.gov/HEALTH/visns.asp.

⁴ VA OIG, [Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims](#), April 27, 2022.

production goals, and oversees personnel management. Compensation Service provides the “how to” guidance, training, and quality assurance checks. The disconnect between the two offices is illustrated through the deficiencies involving MST-related claims processing. The OIG issued two reports on the processing of MST claims, one in 2018 and a follow-up in 2021, which actually showed an increase in incorrect claims processing following the ineffective implementation of OIG recommendations.⁵ In the follow-up report, the OIG found that the Compensation Service and OFO did not communicate effectively to resolve claims-processing problems identified in 2018 and managers and claims processors were not being held accountable for adhering to updated VBA policies and procedures. Communication and cooperation between these offices is crucial to successfully overseeing the processing of claims, and the OIG recommended that VBA develop, implement, and monitor a written plan that requires these two offices to strengthen communication, oversight, and accountability.

The OIG report *Improvements Needed to Ensure Final Disposition of Unclaimed Veterans’ Remains* demonstrates the repercussions of having 27 program offices with responsibilities related to unclaimed remains.⁶ This led to inadequate and ineffective administration and oversight of benefits and services by VHA, VBA, and the National Cemetery Administration (NCA). The OIG team obtained more than 9,000 records from a Department of Justice database and found more than 400 matches of individuals whose remains were unclaimed that appeared to be veterans based on a search of full names and dates of birth and death.⁷ Additionally, the team identified multiple instances of individuals who may be veterans interred in mass graves as well as those with final interments delayed as long as 44 years. There were three key areas in which VA governance of benefits and services for deceased veterans whose remains are unclaimed was not effective: (1) insufficient outreach to funeral homes and other custodians of unclaimed remains and collaboration with external entities to locate deceased veterans and facilitate their burials; (2) a financial oversight structure that did not support cross-administration or VA-wide reconciliation of payments made for these deceased veterans; and (3) inadequate oversight across and within VA’s three administrations.

The problematic decentralized nature of governance is also seen in VA’s financial management structure. Under the Chief Financial Officer (CFO) Act, the VA CFO has the responsibility for establishing financial policy, systems, and operating procedures for all VA financial entities. VA administrations and other offices are responsible for implementing those policies and producing financial information, but they are not under the supervision of the VA CFO. This fragmented structure

⁵ VA OIG, [Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma](#), August 21, 2018; VA OIG, [Improvements Still Needed in Processing Military Sexual Trauma Claims](#), August 5, 2021.

⁶ VA OIG, [Improvements Needed to Ensure Final Disposition of Unclaimed Veterans’ Remains](#), December 15, 2021.

⁷ The National Missing and Unidentified Persons System (NamUs) is the Department of Justice database used. The review team referred all NamUs-matched records to VA for follow-up to conclusively identify veterans and eligible dependents, which may require coordination with the medical examiner, coroner, or law enforcement agency that has custody of the remains.

has been a consistent concern and finding in the audit of VA’s consolidated financial statements.⁸ Without active involvement from VA’s senior leaders to overcome organizational silos and ensure collaboration, problems at the administration level may not be elevated for resolution.

Adequate and Qualified Staff

VA faces high vacancy rates across its programs and operations, especially within VHA. These long-standing shortages of qualified personnel make it difficult for VA to carry out its many goals and functions, impeding its ability to serve the nation’s veterans. Having the right people in the right positions committed to doing the right thing is essential to building a culture of accountability.

To address these staffing shortages, VA has engaged in surge hiring and other recruitment strategies under their expanded authority. While expedient hiring is critical, VA cannot lower its standards for suitability and expertise. A report released last week focuses on suitability (background) checks. It was prompted in part by the recognition that nursing assistant Reta Mays, convicted for murdering seven patients in a West Virginia VA medical center, had not undergone a timely background check that might have prevented her from attaining her position.⁹ In the course of auditing the personnel suitability process across all VA medical facilities, the OIG detected problems with how this process was being conducted at the VA medical center in Beckley, West Virginia. In addition to finding that suitability personnel support was significantly understaffed at Beckley, the review of the facility revealed a need to tighten controls for ensuring individuals are suited for their positions. Thankfully, no patient harm was detected, and all affected personnel had either left VA or were successfully cleared. Making certain that staff are and remain competent to do their jobs is central to the quality assurance issues discussed below as well.

As for persistent shortages, VA is not alone. Medical systems across the country are facing challenges in finding and retaining qualified personnel. The OIG is required by law to conduct an annual review to identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center.¹⁰ In the fiscal year (FY) 2022 review, the OIG found that all 139 VHA facilities that were surveyed reported at least one severe occupational staffing shortage.¹¹ The total number of their reported severe shortages was 2,622. Twenty-two occupations were identified as a severe occupational staffing shortage by at least one in five facilities, including the medical officer and nurse occupations, which have been reported as severe shortages every year since 2014. Practical nurse positions were the most frequently identified “clinical severe occupational staffing shortage” in FY 2022 (62 percent of

⁸ VA OIG, [Audit of VA’s Financial Statements for Fiscal Years 2022 and 2021](#), December 7, 2022.

⁹ VA OIG, [Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia](#), February 23, 2023.

¹⁰ VA Choice and Quality Employment Act, Pub. L. No. 115-46, 131 Stat. 958 (2017).

¹¹ VA OIG, [OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022](#), July 7, 2022.

facilities), with custodial worker and medical support assistance positions being the most frequently reported nonclinical and “Hybrid Title 38” shortages, respectively.¹² The total number of severe occupational staffing shortages increased by 22 percent from the prior year. This was also the first fiscal year that facilities identified more than 90 occupations as severe shortages.

In a recent inspection, the OIG found that inadequate staffing within the Martinsburg, West Virginia, VA medical center’s Care in the Community (CITC) Service led to delays in scheduling community consults (referrals).¹³ Sixty-two percent of the COVID Priority 1 cardiology consults during a one-year period were scheduled more than 30 days beyond the clinically indicated date, which is the date the patient needs to be seen based on their clinical status. To meet workload demands, the CITC Service at the facility needed a minimum of 23 schedulers and 11 clinical employees. At the time of the inspection, they had only 10 scheduling and four clinical staff, with facility leaders reporting significant staff turnover and a lack of training as contributing factors.

In another recent report, the OIG team focused on VA’s accountability for the physical security of its medical facilities.¹⁴ The report identified multiple security vulnerabilities and deficiencies at the time of the review, most notably staffing shortages that contributed to the lack of a visible and active police presence.¹⁵ To meet VA’s established security requirements, facilities need to fill police officer vacancies to correct security weaknesses. Other measures facilities can take to improve campus security include increasing security personnel resources, such as suitable police operations rooms; operable surveillance cameras with consistent monitoring; and adequate equipment. Moreover, the report found that facilities need to do a better job securing doors and restricting public access to high-risk areas. VA concurred with the OIG’s six recommendations, which included delegating a responsible official to monitor and report monthly on facilities’ security-related vacancies; authorizing sufficient staff to inspect VA police forces; and ensuring medical facility directors appropriately assess VA police staffing needs, authorize associated positions, and leverage available mechanisms to fill vacancies.

In addition to addressing staffing shortages, VA should also make sure that its existing personnel are equipped and prepared to do their jobs. The OIG recently reviewed whether staff at VBA were correctly following procedures when requesting medical opinions, a process that is vital to ensuring veterans

¹² In 2003, Public Law 108-170 provided for 21 Title 5 occupations to be converted to “Hybrid” 38 positions, including psychologists, respiratory and physical therapists, and medical technologists. This conversion provided greater benefits related to appointment, advancement, and some pay matters, while retaining some traditional Title 5 employment provisions, including performance appraisals, leave, work schedule, and retirement benefits. *See* 38 U.S.C. §§ 7403 and 7405.

¹³ VA OIG, [Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia](#), February 16, 2022.

¹⁴ VA OIG, [Security and Incident Preparedness at VA Medical Facilities](#), February 22, 2023.

¹⁵ Police staffing shortages have remained in the top 10 most frequently reported positions with severe shortages annually in the OIG’s annual survey of occupational shortages. VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022*.

receive the benefits to which they are entitled.¹⁶ The review found that claims processors did not consistently identify relevant medical evidence for the examiner's review, did not always use clear and accurate language, did not regularly request all warranted medical opinions, and sometimes requested unnecessary medical opinions. One contributing factor to these issues was inadequate training. The mandatory training for claims processors on making medical opinion requests did not explain how to correctly complete the requests using VBA's electronic systems, including what information to input in particular fields. The training also did not describe what constitutes relevant evidence for a medical examiner's review or provide examples of what language should be used to ensure requests are adequate and well written. These failings can lead to inaccurate medical opinions, incorrect decisions on veterans' claims, delayed decisions for veterans, as well as an inefficient use of resources (such as when the medical opinion requires rework).

Modernizing IT Systems and Business Processes

VA is in the process of modernizing a number of significant systems that are critical to its operations. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as the OIG has detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. These issues must be resolved for VA to remain accountable for the care, services, and benefits it provides. VA's process for replacing crucial IT systems, however, faces significant ongoing challenges. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by critical missteps. These have typically included weaknesses in planning, lack of stability in leadership positions, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. The OIG recognizes the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working tirelessly to ensure patient safety and to deliver benefits and services to eligible veterans.

Perhaps the largest contract in VA history, and one that affects patient care, is VA's Electronic Health Record Modernization (EHRM) program. Key objectives of the new system include achieving interoperability of VA and DoD systems to provide complete health records for veterans and enhancing the ability to exchange records with external healthcare providers.¹⁷ Essential to implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, integrated master schedule to ensure all tasks are properly and fully completed and accounted. An OIG audit found, however, that this

¹⁶ VA OIG, [*VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims*](#), September 7, 2022.

¹⁷ VA OIG and DoD OIG, [*Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability*](#), May 5, 2022.

foundational master schedule had significant reliability weaknesses, including missing tasks, no baseline schedule, and no risk analyses.¹⁸ Without remediation, VA cannot offer reliable assurances on timelines and costs. Further, the OIG has estimated that any delay in the program’s completion would cost about \$1.95 billion a year.

Overall, the OIG has released 14 reports on VA’s rollout of the new electronic health record system that identify critical missteps and lack of remediation. Of the 68 recommendations issued to date, 24 have not yet been implemented—with 12 open for more than a year and two open nearly three years. The open recommendations include VA minimizing the number of required mitigation strategies healthcare providers must use when the system goes live, determining whether veterans’ appointments are being scheduled correctly, and addressing unresolved issues related to medication management and care coordination. These reports have also been highlighted in seven congressional hearings in which the OIG testified.¹⁹ Unless VA more effectively engages and coordinates all affected offices and contractors, IT solutions will continue to be delayed, more cost overruns will occur, and the risk to patients and VA operations will increase.

Although VA paused its EHRM rollout in June 2022, users of the new system continue to raise troubling complaints that the system hinders the delivery of prompt, high-quality patient care. The effects on staff, workload, and the risks for errors are also concerning. The OIG is continuing its oversight, including an examination of system degradations and outages.

Similarly, there are other key systems essential to maintaining effective and efficient VA operations in other areas that are also in critical need of updates or replacement. In March 2019, VA decided to modernize and standardize its supply chain management, replacing up to 12 legacy systems with a system already in use at DoD—the Defense Medical Logistics Standard Support (DMLSS) system. The OIG reviewed VA’s oversight and coordination of the system’s implementation at the pilot site to identify challenges that could affect supplies getting to where and when they are needed and to inform future deployments.²⁰ The OIG found that the system did not meet more than 40 percent of the high-priority essential business requirements identified by VA medical facility staff at the pilot site. This occurred because the VA Logistics Redesign (VALOR) program manager did not follow VA’s acquisition framework as required. After months of trying to determine the way ahead, VA announced in December 2022 that it will not deploy the DMLSS multibillion-dollar supply chain management

¹⁸ VA OIG, *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule*, April 25, 2022.

¹⁹ Prior EHRM congressional statements can be found at www.va.gov/oig/publications/statements.asp.

²⁰ VA OIG, *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays*, November 10, 2021.

system across the department's health and medical services.²¹ In considering next steps, supply chain modernization is not just about the system; it is about the people, processes, and technology limitations. Without clear roles and responsibilities, business requirements, and effective tools, VA will struggle to achieve accountability for its multibillion-dollar logistics portfolio.

Making sure veterans are promptly and accurately provided benefits is one of VA's most important responsibilities, yet it is often hindered by outdated IT systems and unclear or complex business processes. For example, VA improperly created debts in veterans' accounts when reducing disability levels. In a national review of the issue, the OIG found instances in which VA employees retroactively reduced disability levels and erroneously created debts without always informing veterans—in part due to system limitations. Based on the review of a statistical sample, the OIG estimated errors resulting in incorrectly created veteran debts totaling about \$13.4 million.²²

The OIG has also released a series of reports on GI bill benefits in response to concerns that eligible beneficiaries were not getting payments owed to them or were being underpaid.²³ Starting with an issue statement in 2019, the OIG identified delays in system modifications needed to satisfy the statutory requirements, in part due to the lack of an accountable official to oversee the project.²⁴ The OIG team found that approximately 10 months passed from the time Congress enacted the Forever GI Bill until VA received the initial software development release and began testing the system modifications. VA's testing of the software development release identified defects, prompting the development of additional versions. Based on interviews, when user testing occurred, there were failures related to scenarios that VBA did not account for when personnel developed the business requirements. In a recent report on the Post-9/11 GI Bill, the OIG found errors in VBA's processing of school vacation breaks due to the process being entirely manual, resulting in about \$624,000 in underpayments to beneficiaries for monthly housing allowances and college funds.²⁵

Another report indicated improper payments were being made to veterans who were deceased because VA needed to better monitor its death match records automated process, and VBA missed opportunities

²¹ Edward Graham, "VA Cancels Future Deployments of New Supply Chain Management System," *Nextgov*, December, 13, 2022, <https://www.nextgov.com/technology-news/2022/12/va-cancels-future-deployments-new-supply-chain-management-system/380841/>. The article states that the decision to abandon DMLSS deployment followed the OIG report findings.

²² VA OIG, *VBA Improperly Created Debts When Reducing Veterans' Disability Levels*, July 28, 2022.

²³ VA OIG, *Forever GI Bill: Early Implementation Challenges*, March 20, 2019; VA OIG, *Controls Appear to Have Addressed Prior Overpayments of Post-9/11 GI Bill Monthly Housing Allowance*, June 23, 2020; VA OIG Management Advisory Memorandum, *Post-9/11 GI Bill Non-College Degree Entitlement Calculations Lead to Differences in Housing Allowance Payments*, January 19, 2021; VA OIG, *Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement*, May 3, 2022.

²⁴ VA OIG, *Forever GI Bill: Early Implementation Challenges*.

²⁵ VA OIG, *Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement*.

to discontinue payments by not coordinating with and obtaining data from VHA.²⁶ In one case, payments continued to be improperly paid to a veteran who was deceased for a total of about \$99,000.²⁷ An automated system also was to blame for improper processing of pension reductions as detailed in a 2021 report, leading to veterans not being notified that their benefits were being reduced or given the information necessary to appeal those reductions. All of the estimated 13,100 cases contained notification errors that made it difficult for beneficiaries to determine what action they should take, such as submitting evidence that the benefit should not be reduced or requesting a hearing. Errors identified were the result of inadequate planning and implementation of the automated pension reduction process.²⁸

VA has also been struggling since the early 2000s to replace its financial management system. After several failed attempts in 2004 and 2010, VA used the lessons learned and established the Financial Management Business Transformation (FMBT) program. The program's mission is to increase the transparency, accuracy, timeliness, and reliability of financial information across VA, ultimately resulting in improved care and services for veterans and accountability to taxpayers. Central to the FMBT program's modernization efforts is the multiyear, phased deployment of the Integrated Financial and Acquisition Management System (iFAMS) beginning with NCA. In September 2021, the OIG issued a management advisory memorandum on inadequate business intelligence reporting capabilities in iFAMS that hindered NCA's ability to easily monitor its budget and operations.²⁹ In June 2022, the OIG issued another memorandum on the results of a consulting engagement related to financial reporting controls for iFAMS at NCA.³⁰ This memorandum identified risks that could lead to inaccurate financial reporting, including interface errors, more manual data entry, and the lack of automated controls. VA is currently reviewing a draft report related to the deployment of iFAMS at NCA that discusses issues that should be addressed as VA moves forward with further deployment of iFAMS.

Quality Assurance, Monitoring, and Reviews

VA often lacks controls that effectively and consistently ensure quality standards are met. Routine monitoring breakdowns and workarounds undermine efforts to ensure eligible veterans and their

²⁶ VA OIG, [Additional Actions Can Help Prevent Benefits Payments from Being Sent to Deceased Veterans](#), April 21, 2022.

²⁷ In a recent OIG criminal investigation, the daughter of a deceased widow who had been receiving VA survivors benefits continued to receive those benefits even after her mother passed by forging her mother's signature and fraudulently filing VA paperwork to make it appear as if her mother was still alive. The daughter was ordered to pay restitution of almost \$462,000. VA OIG, [Monthly Highlights](#), January 2023.

²⁸ VA OIG, [Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments](#), October 28, 2021.

²⁹ VA OIG, [Inadequate Business Intelligence Reporting Capabilities in the Integrated Financial and Acquisition Management System](#), September 8, 2021.

³⁰ VA OIG, [Results of Consulting Engagement Related to Selected Financial Reporting Controls for the Integrated Financial and Acquisition Management System at the National Cemetery Administration](#), June 15, 2022.

families receive timely quality services and benefits. Failures in quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly in areas such as credentialing, privileging, and monitoring of healthcare personnel entrusted with veterans’ care.

VBA and VHA programs have various types of quality assurance programs; however, they are not consistently and effectively implemented, and the results are not always clearly communicated or resolved. Among the many reports the OIG has published, a series of four focused reports and a roll-up report have been released on VBA’s multifaceted quality assurance program.³¹ The program is managed by VBA’s Compensation Service, but VBA’s OFO is responsible for ensuring regional office employees adequately address claims-processing deficiencies routinely identified by the quality assurance program. The individual reports on elements of the quality assurance program identified weaknesses in the program, and the summary report identified systemic weaknesses in OFO’s oversight and accountability. Two aspects of the quality assurance program are the Systematic Technical Accuracy Review Program and the Quality Review Team Program. However, OIG staff have observed those programs focus on an *overall* statistical sample of completed disability compensation claims. That means that complex claims, such as claims for military sexual trauma and ALS (Lou Gehrig’s disease), are not the focus of the sample. Processing deficiencies related specifically to these complex claims may go undetected if they are simply grouped with claims at lower risk for error. Without more focused sampling, quality assurance results provide incomplete information to VBA on how well staff are processing claims more vulnerable to error.

One of the OIG’s reports on VBA’s quality assurance program examined VBA’s site visit program of regional benefits offices, which is designed to not only correct deficiencies at individual regional offices, but also to identify error trends across multiple regions that could be used to drive nationwide improvements in claims processing. The OIG reviewed the site visit reports for 47 regional offices and found that almost 50 percent had deficient workload management plans, 36 percent had no plans at all to clear the backlog of errors pending correction identified by quality review teams, and 23 percent were deficient in MST claims processing.³² While the site visit program identified these and other frequently recurring deficiencies, OFO did not require all offices across the country to apply the information to ensure widespread improvements. As a result, VBA missed opportunities to provide impactful oversight and drive positive change, which could ultimately improve the accuracy and consistency of veterans’

³¹ VA OIG, [The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies](#), July 22, 2020; VA OIG, [Deficiencies in the Quality Review Team Program](#), July 22, 2020; VA OIG, [Site Visit Program Can Do More to Improve Nationwide Claims Processing](#), August 18, 2020; VA OIG, [Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide](#), September 29, 2020; VA OIG, [The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings](#), May 18, 2021.

³² VA OIG, [Site Visit Program Can Do More to Improve Nationwide Claims Processing](#).

disability benefit decisions. Until VBA leaders ensure improvements are made, veterans may not get the benefits to which they are entitled.

VA has identified patient safety as a top priority.³³ Healthcare facilities committed to patient safety routinely follow protocols that prioritize high-quality care and have a structured and proactive quality and safety management oversight team. OIG reports, however, routinely identify instances in which staff fail to adhere to policy or to take actions that ensure a culture of patient safety. For example, a recent OIG report found that the Tuscaloosa VA Medical Center and VISN 7 had insufficient oversight of the facility's Patient Safety Program.³⁴ The OIG received a VHA Issue Brief identifying concerns with the program's management not completing the required patient safety root cause analyses and risk assessments, and the former Patient Safety Manager (PSM) not attending meetings with facility and VISN committees. These concerns followed the extended leave and abrupt retirement of the former PSM. The OIG substantiated the concerns and identified other issues with program oversight and the facility's culture of safety. According to the report, the facility and VISN leaders did not take appropriate action. Facility leaders failed to fully engage with Patient Safety Program staff and did not sufficiently use available tools to assess and evaluate reported concerns related to patient safety, putting patients at unnecessary risk.

Ensuring high-quality patient care was also identified in a report on the Columbia VA Health Care System in South Carolina.³⁵ That report focused on adverse clinical outcomes for three patients. While reviewing the allegations related to those patients, the OIG found weaknesses in the peer review and quality management processes. The peer reviews and the peer review committee practices were inefficient and there was a delay in the initiation of an institutional disclosure to the patient's family and completion of a root cause analysis of the problem. All seven of the report's recommendations remain open, including three focused on the facility's quality management program.

Proper documentation practices are an important aspect of accountability in both benefits and healthcare settings. Those practices help VA and oversight entities ensure that policies and requirements are being met. In healthcare settings, proper documentation is especially critical as it communicates to members of an integrated healthcare team critical data that are necessary to ensure coordination and collaboration. For example, in an inspection of the VA Pittsburgh Healthcare System, the OIG found that failures in completing a thorough assessment and documentation may have contributed to a lack of appropriate

³³ See, e.g., VA, "Patient safety a primary concern at VA," March 15, 2021, <https://news.va.gov/85809/patient-safety-primary-concern-va/>, and "VHA National Center for Patient Safety" (web page), VA, <https://www.patientsafety.va.gov/about/approach.asp>.

³⁴ VA OIG, *Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama*, February 27, 2023.

³⁵ VA OIG, *Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina*, September 27, 2022.

intervention and ultimately an adverse clinical outcome for a patient.³⁶ A behavioral health nurse practitioner did not document a comprehensive suicide risk assessment for eight patients, even though this was required based on their positive screen for suicidal ideation. The nurse practitioner also failed to consistently document intent, risk and protective factors, and a mitigation plan for the patients. The OIG also found that a nurse manager who was responsible for conducting ongoing professional practice evaluations (OPPE) had given this nurse practitioner a “satisfactory” rating for the “safety plan completion for high risk for suicide patients” and “copy and paste use” elements—even though the nurse manager admitted to not reviewing these elements of documentation. In fact, the inspection team found that the nurse practitioner not only failed to complete a safety plan for eight patients, but also inappropriately copied and pasted significant sections of notes from prior documented clinical encounters. The OIG’s recommendations centered on the improvement of assessment and documentation practices, verification of the review of performance elements in OPPEs, and manager oversight of those OPPEs.

Quality controls and process monitoring must be coupled with ensuring the competency of personnel to meet the requirements of their position and their commitment to serving veterans. Delayed responses to concerns related to the competency of healthcare providers cannot only put patients at risk and compromise the trust of staff, but can negatively affect the skills and practices of the providers in question. A report on the Richard L. Roudebush medical center in Indiana highlights this issue.³⁷ The cardiology nursing staff had expressed multiple concerns to facility leaders regarding the skills of a newly trained interventional cardiologist. As a result, the cardiologist’s cardiac catheterization laboratory privileges were suspended and a factfinding investigation was initiated. However, these actions were not completed in a timely manner. The factfinding investigation was finalized more than three months after the cardiologist’s suspension, and it took almost another three months for the cardiologist’s privileges to be reinstated so that leaders could initiate a second observed evaluation of the cardiologist’s performance in the catheterization laboratory. After six months out of practice, the cardiologist refused to participate in a practice review and resigned. Ultimately, the OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility.

Stable Leadership That Fosters Responsibility and Continuous Improvement

VA leaders at every level often do not get the information they need to make effective decisions; some fail to take necessary and prompt action, while others struggle to create a culture where every employee feels empowered to report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

³⁶ VA OIG, [*Deficiencies in a Behavioral Health Provider’s Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania*](#), May 3, 2022.

³⁷ VA OIG, [*Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*](#), January 17, 2023.

The OIG's recent report on the mistreatment of a patient admitted to the Miles City Community Living Center (CLC), part of the VA Montana Healthcare System in Fort Harrison, describes failures in leadership that led to several incidents of patient abuse.³⁸ The OIG learned that nurses and a physical therapist forced a critically ill patient to walk after the patient verbally refused and lowered to the floor to further refuse participation. Staff reported the physical therapist, and a nurse forcefully lifted the patient by the arm to stand and then pulled the patient's walker forward and out of reach, compelling the patient to walk. A VA police report documented bruises to the patient's arms, and staff told the OIG that the patient sustained skin tears during this session. The OIG concluded that the physical therapist and nurses violated VHA policy by failing to respect the patient's right to refuse treatment and subjecting the patient to mistreatment during two physical therapy sessions. The OIG also determined that there were three previous investigations with confirmed findings of mistreatment or abuse in the CLC. Two nurses involved in the mistreatment of this patient were also involved in two of the other incidents, one in a 2018 incident and both in an August 2020 incident. The OIG determined that facility leaders did not complete oversight processes for the CLC, including intervening in prior findings of CLC patient mistreatment in 2018 and 2020. Facility leaders also failed to oversee the sole physician responsible for the CLC patients. The lack of oversight repeatedly placed patients at risk. With a distance of over 350 miles to the Fort Harrison facility, staff easily escaped accountability.

The Montana case is an example of a culture the OIG has found in other facilities that did not foster the prompt and candid reporting of concerns. Leaders' failures to create a culture in which personnel feel safe in reporting clinical personnel's incompetency or errors can lead to tragic outcomes. For example, in a 2021 report, the OIG detailed how Dr. Robert M. Levy, the former pathologist at the VA Health Care System of the Ozarks in Fayetteville, Arkansas, was found to have been working while impaired by substance use and misdiagnosed thousands of patients' pathological specimens. His errors resulted in some veterans not being diagnosed with cancers for which they needed prompt and tailored treatments and others undergoing interventions they did not need—some with significant side effects. In addition, in his position as chief of pathology, he was able to alter quality management documents to conceal his errors.³⁹ Dr. Levy was sentenced to 20 years in federal prison (including one count of involuntary manslaughter), followed by three years of supervised release, and ordered to pay \$497,745 in restitution.⁴⁰ Like the Reta Mays serial murder case mentioned earlier, personnel had concerns regarding

³⁸ VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*, January 26, 2023.

³⁹ VA OIG, *Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, June 2, 2021.

⁴⁰ U.S. Department of Justice, "Fayetteville Doctor Sentenced to 20 Years in Federal Prison for Mail Fraud and Involuntary Manslaughter," January 22, 2021, www.justice.gov/usao-wdar/pr/fayetteville-doctor-sentenced-20-years-federal-prison-mail-fraud-and-involuntary.

the circumstances surrounding the hypoglycemic events, but not all personnel promptly reported concerns and there were insufficient follow-up actions taken.

In a number of OIG reports, leaders' stated commitment to improvement is not reflected in closing, sustaining, or fully implementing recommendations for corrective action.⁴¹ As stated earlier, the OIG has reviewed VBA's processing of posttraumatic stress disorder (PTSD) claims related to MST several times due to delays in implementing recommendations for improvement or sustaining those corrective actions. In August 2018, the OIG found that claims processors did not follow the proper procedures for about half of denied claims to veterans, resulting in premature denials. The OIG made six recommendations including calling for VBA to have MST claims handled by a specialized group of claims processors. In response, VBA identified a list of designated claims processors and in January 2019 established a procedure requiring that only designated employees process MST claims.⁴²

However, in August 2021, the OIG concluded in a follow-up to the 2018 report that VBA leaders had not sustained the corrective actions.⁴³ About 80 percent of claims denied from October 1 through December 31, 2019, were processed by one or more VBA employees who were not designated MST claims processors. Based on a sample of claims processed after VBA acted on the prior OIG recommendations, the review team estimated about 620 of 1,100 denied claims (57 percent) were incorrectly processed, which was not an improvement from the previous error rate.

VA has a special obligation to provide veterans who are claiming benefits every opportunity to support their claims. Leadership duties do not end when the OIG closes a recommendation based on VA-provided documentation that demonstrates sufficient plans and steps have been taken to address identified issues. Leaders must instill in all VA personnel a commitment to continuous improvement, including fully addressing and sustaining corrective actions taken in response to OIG recommendations.

A lack of commitment to full transparency in reporting operational problems can also hinder OIG and other oversight. In reviewing VA's new electronic health record (EHR) system at the Mann-Grandstaff VA Medical Center in Spokane, Washington, the OIG found that leaders in what was then the VA Office of Electronic Health Record Modernization (OEHRM) showed a careless disregard for the accuracy and completeness of the information they provided, and that those leaders' lack of due care and diligence resulted in misinformation being submitted to OIG staff.⁴⁴ The OIG recommended that the program's leaders clarify to their personnel that all staff have a right to speak directly and openly with

⁴¹ See, e.g., VA OIG, [Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits](#), December 15, 2021.

⁴² VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*.

⁴³ VA OIG, *Improvements Still Needed in Processing Military Sexual Trauma Claims*.

⁴⁴ VA OIG, [Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), July 8, 2021. In December 2021, OEHRM was restructured to form the Electronic Health Record Modernization Integration Office (EHRM IO).

OIG staff and ensure that direct communication with OIG staff is not impeded when needed to clarify requests or responses.⁴⁵

Conclusion

There is no question that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. They often have to navigate obstacles and overcome challenges to make certain that patients receive prompt high-quality care and that veterans and other eligible beneficiaries receive the compensation and services they are owed. Unfortunately, the OIG has found that VA has struggled with the foundations of accountability, including strong governance and clarity of roles and responsibilities; adequate and qualified staffing; updated IT systems and effectual business processes; effective quality assurance and monitoring; and stable leadership that fosters responsibility for actions and continuous improvement. Without a greater emphasis on these areas of accountability, VA will not always provide the highest-quality care, benefits, and services to veterans and their families.

⁴⁵ VA OIG, [*Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training*](#), July 14, 2022.