DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Department of Veterans Affairs

Fiscal Year 2022 Inspector General's Report on VA's Major Management and Performance Challenges

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FOREWORD

The Office of Inspector General's (OIG) mission is to serve veterans, their families and caregivers, and the public by conducting effective oversight of VA programs and personnel. Our oversight reports recommend enhancements to VA services, operations, processes, and systems that will help improve the lives of veterans and make the best use of taxpayer dollars. Each year, the Inspector General is required to provide an annual update summarizing VA's top management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

This year's major management challenges for VA continue to align with the OIG's strategic goals for addressing five areas of ongoing concern: (1) healthcare services, (2) benefits, (3) stewardship of taxpayer dollars, (4) information systems and innovation, and (5) leadership and governance. The OIG conducts extensive oversight of VA programs and operations in each of these five areas through independent audits, inspections, investigations, and reviews. The challenges in these areas have been identified by OIG personnel, external oversight agencies and organizations, the veteran community, Congress, and other stakeholders. They reflect the OIG staff's unwavering commitment to our mission.

As we release this report, VA has a newly confirmed leader to oversee the nation's largest integrated public healthcare system; the National Cemetery Administration's leader has been in place for more than a year; and the benefits administration is being directed by a senior official serving as the acting undersecretary. The challenges they face are considerable as VA works to implement key systems modernization, such as the new electronic health record system; address staffing shortages and aging infrastructure; and respond to rapidly expanding programs, such as the PACT Act's extension of toxic exposure benefits to millions more veterans. VA personnel have continued to battle burnout and pandemic fallout as they have provided care, services, and benefits to veterans, their families, and communities. OIG staff are committed to providing fair and evidence-based oversight to help VA leaders and personnel make advancements in serving veterans and other beneficiaries while making the most effective use of taxpayer dollars.

MICHAEL J. MISSAL
Inspector General

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OIG CHALLENGE #1: HEALTHCARE SERVICES

Overall, VHA has been steadfastly meeting the healthcare needs of millions of veterans each year, particularly those with distinct and often complex diagnoses related to their service to our country. Among its many efforts, VHA has pioneered evidence-based mental health therapies and innovative approaches to treating victims of polytrauma and traumatic brain injury, and successfully served and supported veterans with chronic and often catastrophic visible and invisible injuries.

However, issues such as staffing shortages, the ongoing effects of the pandemic, barriers to care coordination, and systems failures that put patient safety at risk (see challenges 4 and 5 on electronic health records) have continued to pose significant challenges for VHA staff and leaders. OIG reports highlight such problems involving inadequate VHA reviews of provider performance and alleged misconduct, infection control practices, critical supply management, medication management, and telehealth device monitoring and administration that provide high-quality care in a safe environment to address a wide range of patient needs.

No other healthcare system is laser-focused on meeting the clinical needs of veterans in every encounter, while also addressing a broad range of psychosocial supports. However, not all veterans receive their care at VA facilities, and trying to provide the same quality of care in the community presents its own set of oversight and administrative challenges. VHA leaders are responsible for ensuring that patients receive quality care, treatment, and services that are always safe and effective, regardless of whether it is delivered by VA or non-VA providers.

Many VA OIG publications, including individual inspections, national reviews, and comprehensive healthcare inspection program reports have addressed the importance of improving the patient safety culture, and other VA OIG publications have also addressed concerns regarding prompt access to care, especially quality mental health care for high-risk veterans.

Why This Is a Challenge

The OIG found that all 139 VHA facilities reported at least one severe occupational staffing shortage. The total number of reported severe shortages was 2,622. Every year since 2014, the medical officer and nurse occupations were reported as severe shortages. Fiscal year (FY) 2022 was the first time that facilities identified more than 90 occupations as severe shortages, with a clear ongoing need for custodial workers and medical support assistance. The pandemic and competition from the private sector are just two contributing factors.

Burdens related to workforce fatigue and referral backlogs resulting from the pandemic have also increased the demand for care in the community. Coordination of the provision of medical care between the VHA healthcare system and community providers remains a significant challenge.

Persistent administrative and communication errors, electronic record limitations, and failures between VHA and community care providers, as well as between the providers and their patients, undermine efforts to ensure a seamless experience for veterans.

For example, at the VA Phoenix Health Care System in Arizona, the OIG found that staff did not review a patient's initial community care consult for a mental health evaluation within the required time frame. Although a third-party administrator eventually scheduled the patient once the referral was approved, the patient was scheduled for the wrong intervention. These delays and processing errors resulted in missed opportunities to appropriately diagnose and address the needs of a patient who ultimately died by suicide.

As another example, the OIG substantiated an allegation that between June 2018 and June 2020, VHA Community Care nurses at the VA New Mexico Healthcare System in Albuquerque were completing consults (referrals) without scanning and attaching clinical documentation to the patients' electronic health records. While VHA care providers developed workarounds to obtain information necessary to meet their patients' needs, such strategies distract from their primary duties to care for veterans and increase the risk of human error in coordinating safe and effective care.

Given VA's goal of reducing suicide and addressing the burden of mental health issues, a shortage of qualified mental health providers means VHA must innovate to expand the reach of its providers and those in its community network. Many of the issues veterans face are multifactorial and demand prompt and accurate communications between VHA and community service or care providers. Coordination of that care and reliable information sharing across all providers are critical to ensuring demand is met in a seamless and safe manner and accurate information is communicated to patients.

The criticality of coordinated care is nowhere more visible than in VA's suicide crisis line. Its responders are often the vital link between at-risk veterans and prompt VHA or community care. VA encourages veterans and their loved ones to call when a veteran is in crisis, particularly when at risk for suicide. The crisis line responders provide veterans a broad range of assistance, from providing requested information on VA services or programs to conducting crisis intervention care services in the community.

Suicide prevention coordinators are essential to veterans receiving needed care. Coordinators are required to reach out to veterans who have contacted the crisis line and accepted a referral. Continued follow-up allows coordinators and other medical facility staff to ensure the veteran is safe and connected with appropriate care, benefits, or services within the VA system or in the community, and they perform additional suicide risk assessments. However, OIG reports have highlighted that some crisis line reporting data were not accurate because some coordinators mistakenly closed referrals using system codes that indicated they had reached the veteran when they had not. Also, the OIG has reported that some coordinators did not always follow up with veterans who received suicide intervention care in the community as required.

These conditions occurred because VHA and VISN and medical facility management officials needed to enhance the management of crisis line referrals and coordinator supervision. Strengthened training, guidance, and monitoring of crisis line referrals would improve coordinator performance. Without it, coordinators could continue closing referrals improperly and miss opportunities to assist at-risk veterans.

What VA Needs to Do

It is critical that hospitals have effective core services that promote quality care and patient safety and ensure key operations are running efficiently. VA has developed a diverse range of outreach programs, including for suicide prevention and firearms safety efforts. However, many of these programs are provided through the social work function and less routine methods that are not as well monitored by traditional hospital performance metrics. VA needs to address OIG-identified deficiencies using data-driven approaches. Leaders should develop processes to monitor specific outreach program performance of VA facilities against the relevant directives and better integrate VA social work activities that draw on non-VA resources in the community.

OIG oversight has also revealed that VHA's Office of Community Care needs to collaborate more effectively with other clinical program offices to evaluate how often user training is provided on the new technology for documenting the processes for scheduling community care consults.

Responsible staff are not always documenting information about routine community care consults in patients' records. This includes consistently recording contact attempts, updating contact information, and designating whether alternative forms of care are appropriate for the patient. VHA can also improve the consult process by ensuring that all those who process community care referrals have the information and training needed to schedule them efficiently and use all available scheduling tools.

OIG CHALLENGE #2: BENEFITS FOR VETERANS

Claims processing is at the core of providing myriad types of benefits, including disability compensation, education and vocational training, and pension benefits to the nation's veterans, as well as for compensation or benefits for their eligible family members and caregivers. The complex processes with mandated timelines require continuous monitoring and oversight by VBA leaders and personnel.

Among the many OIG-identified challenges for VBA are the processes associated with contracted medical examinations for disability claims processing. There is a noted lack of governance and accountability over exam contracts. Improvements in instructions to examiners and implementing other OIG recommendations would lead to more accurate exam results, better decisions and use of funds, and more veterans receiving the benefits for which they are eligible.

Also, recent OIG reports have highlighted that some claims processing has suffered from lack of oversight, guidance, and claims processors with sufficient experience to review complex claims. The demands on VBA are expected to escalate following the recent passage of the PACT Act, which expands VA health care and benefits for veterans exposed to burn pits and other toxic substances. The PACT Act is perhaps the largest healthcare and benefit expansion in VA history, extending eligibility to millions of combat veterans by adding 23 new presumptive conditions for burn pits and other toxic exposures and more presumptive-exposure locations for Agent Orange and radiation.

Why This Is a Challenge

The diversity of claims and the abundance of laws, policies, and procedures require continuous monitoring to incorporate updates, standardize decisions, and identify errors, which all could affect the accuracy of benefits decisions. VBA is completing more compensation claims than ever before. More than three million claims were processed in the past three fiscal years, triple the amount completed in 2000. However, OIG reporting shows that VBA's attempts at efficiency sometimes come at the cost of negative consequences for veterans. Since 2018, the OIG has issued at least four reports that demonstrate VBA personnel did not fully consider the effect their decisions would have on veterans and other beneficiaries. These decisions led to improper payments to veterans and their families, violations of veterans' due process rights, disclosure of veterans' personal information, and veterans undergoing unnecessary medical examinations. Other factors that contribute to errors and delays in claims processing include inadequate training or expertise, updates to processes, and oversight.

Several OIG reports highlight these deficiencies. For example, an OIG report found that in three distinct samples of claimed medical conditions commonly associated with burn pit exposure, VBA denials were premature. As a result, veterans may not have received the benefits for which they could be eligible because a determination of whether a condition was due to burn pit exposure was not fully developed. Incomplete development included failing to request opinions from medical examiners about whether conditions were "as likely as not" due to burn pit exposure, as required. Premature denials were also due to confusing guidance about how to process burn pit-related claims and lack of focused quality assurance.

OIG staff also found Camp Lejeune contaminated water claims were incorrectly processed due to staff having limited experience processing these types of claims. Aside from the Louisville Regional Office where most of the claims were processed by experienced staff, the remaining regional offices did not have dedicated teams, resulting in much higher error rates.

A similar lack of specialized claims processing experience and training is evident in the OIG's oversight of claims related to military sexual trauma (MST). In December 2010, the OIG determined a lack of specialized training for claims processors contributed to inconsistent evaluations and processing. In an August 2018 report, the OIG identified several processing

deficiencies that led to the premature denial of nearly half of the reviewed denied MST-related claims. This was due to lack of specialization, insufficient staff training, inadequate internal controls, and discontinued focus reviews. An August 2021 report demonstrated that VBA's claims processors were not following the policies and procedures updated in response to prior OIG recommendations for processing MST-related claims. That same month, the OIG reported a number of MST coordinators at VA medical facilities were unable to fulfill their roles and responsibilities due to insufficiently protected administrative time, role demands, support staff, and inadequate funding and outreach materials.

What VA Needs to Do

The continued review of VBA's performance metrics is needed, such as those for exam timeliness tracked both monthly and quarterly. These metrics should be compared to vendor performance metrics in the Performance Work Statement to assess vendor performance. Other improvements include system enhancements, such as prohibiting VBA rating veterans service representatives from bypassing statutory housebound validation warnings without taking action or providing justification when processing special monthly compensation housebound benefits. Guidance should be improved, such as with Education Services staff updating the School Certifying Official Handbook and offering training aids to clearly detail how to better calculate and report attendance information for students. VBA officials have indicated that modernization efforts, specifically the Digital GI Bill, will improve the automated processing of education enrollments.

VBA should continue to implement controls to improve accuracy, including through its Systematic Technical Accuracy Review program. For example, Compensation Service personnel run a quarterly report through the remainder of FY 2022 to review claims related to burn pit exposure. If errors or trends are identified, Quality Assurance staff are expected to prepare reports and convene calls to ensure claims processors are aware of the trends detected and will make corrections to identified errors.

Also, VBA needs to update its adjudication procedures manual to provide separate and specific guidance for when claims should be considered based on burn pit exposure as well as proper development of these claims. In addition, VBA should modify the examination request application to add specialty language to medical opinion requests for burn pit exposure claims. VBA should also update training materials to ensure they are consistent with the adjudication procedures manual guidance for developing burn pit exposure claims.

VBA has an obligation to ensure eligible veterans receive the benefits to which they are entitled. This requires VBA to properly consider all requisite claim elements and relevant circumstances, conduct reviews to identify errors, and continuously improve its processes to correct those errors. As many OIG reports have stated, VBA leaders need to assess their governance structures,

including responsibility for program oversight and implementing systems-level changes to improve the accuracy of claims processing.

OIG CHALLENGE #3: STEWARDSHIP OF TAXPAYER DOLLARS

Many OIG reports focus on wasteful spending, as with supplies, telehealth device plans, or pharmaceuticals that have not been properly managed. Often these are associated with information technology (IT) system failures discussed below. Other areas include overpayment of benefits to veterans due to claims processing issues and administrative errors. Still others relate to losses associated with undetected fraud. These are just some of the many areas in which VA is challenged to address inefficiencies, detect criminal activity, and prevent waste.

Complicating matters, VA's legacy Financial Management System (FMS), implemented in 1992, is complex and disjointed, has limited functionality, and no longer supports the stringent and demanding financial management and reporting requirements mandated by the Department of the Treasury and Office of Management and Budget. VA uses a system application, the Management Information Exchange system, to consolidate general ledger activities from FMS and create financial statements for external financial reporting; however, each accounting period in the Management Information Exchange system is independent. Therefore, numerous journal vouchers, reconciliations, and analyses must be manually redone and reentered in each period to produce VA's financial statements and trial balances. This significant manual intervention creates risks to the accuracy and completeness of financial reporting activities and reports.

Why This Is a Challenge

As described below, many of the challenges that undermine efforts to make the most effective use of taxpayer dollars can be traced to deficient systems and governance issues. Persistent issues also require extensive efforts to change business processes, research legacy differences, and implement workarounds or more lasting solutions to resolve them. Other contributing factors include the following:

Questionable controls over significant program accounting estimates: VBA models such as those used to estimate the compensation, education, and loan guarantee programs need improvement, continuous updating, and management's unflagging focus.

Decentralized and disjointed financial systems and reporting: As stated above, VA's legacy core financial management and general ledger system, FMS, cannot meet current financial management and reporting needs. VA continues to record many journal entries in FMS using manual processes and reconciliations to produce a set of auditable financial statements. Further, various financial reporting issues persist due to its decentralized infrastructure, though improvements have occurred in certain areas.

Serious control weaknesses throughout the organization with respect to financial reporting: These weaknesses are attributed to a decentralized and fragmented organizational structure for financial management; weaknesses in risk assessment and monitoring; the lack of an effective, comprehensive, and integrated financial management system; a challenging IT environment; and the reliance VA places on manual processes to identify or correct errors with financial information.

Without the deliberate and universal implementation of a centralized and testable financial management application, VA's history of noncompliance with major financial management regulations will continue. Previous OIG reports have identified the following:

- Substantial noncompliance with federal financial management systems requirements and the United States Standard General Ledger requirements at the transaction level under the Federal Financial Management Improvement Act of 1996, reported in part for more than 10 years.
- Improvements need to fully comply with the intent of the Federal Managers' Financial Integrity Act, reported since 2015.
- Instances of noncompliance with Title 38 of the United States Code, section 5315, pertaining to the charging of interest and administrative costs, reported for more than 10 years.
- One reported violation of the Antideficiency Act, Title 31 of the United States Code, section 1341 (a), in November 2020, and as of this publication the OIG is still examining whether another violation may have occurred. However, five other potential violations have carried forward from prior years and remain unresolved and under discussion with the Office of Management and Budget. Actual or potential violations of the Antideficiency Act have been reported each year since FY 2012.

Noncompliance with the Improper Payments Elimination and Recovery Act for FY 2021, as reported by the OIG since 2012.

What VA Needs to Do

VA's Financial Management Business Transformation (FMBT) program has initiated deployment of the Integrated Financial and Acquisition Management System (iFAMS)—a streamlined, federally compliant, and Cloud-hosted financial and acquisition solution with business processes and capabilities. Through the iFAMS implementation, FMBT reports it will increase the transparency, accuracy, timeliness, and reliability of financial information across VA. FMBT will fully implement iFAMS by FY 2028. This is meant to result in improved fiscal accountability to taxpayers and in strengthening the Department's ability to provide care and services to veterans. Additionally, VA proposes that iFAMS will help to resolve a material weakness on its annual financial statements and increase its operational efficiency, productivity, agility, and flexibility.

VA needs to monitor the transition to iFAMS, to include establishing a plan to transfer data, sunset all legacy financial management applications currently used, and transition to the sole use of iFAMS.

OIG CHALLENGE #4: INFORMATION SYSTEMS AND INNOVATION

As the second largest federal agency, VA's wide-ranging IT systems and networks are critical to the provision of medical care, benefits, and services to millions of veterans and their families. VA is responsible for storing, managing, and providing secure access to enormous amounts of sensitive data, such as veterans' medical records, benefits determinations, financial disclosures, and education records. The OIG recognizes and appreciates that this is a tremendously complex undertaking. Safeguarding the secure operation of the systems and networks that contain this sensitive data is essential, especially with the wide availability and effectiveness of internet-based hacking tools. Without proper measures, these systems and networks are vulnerable to groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other VA systems.

Why This Is a Challenge

VA's antiquated systems are burdensome, costly to maintain, cumbersome to operate, and difficult to adapt to VA's continuously advancing operational and security requirements. Developing and maintaining adequate safeguards is made more complex by VA's obsolete legacy systems. Given the risks associated with using outdated systems, internal controls over operations take on even greater importance to sustain the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other criminal acts. It is vital that VA's IT investments are carefully deployed and monitored. To the extent that VA does not properly manage and secure its IT investments, they can become increasingly vulnerable to misuse and mishaps. Security failures also undermine the trust veterans put in VA to protect their sensitive information, which can affect their engagement with programs and services.

In addition, the OIG has found the Office of Information and Technology (OIT) has not consistently ensured adequate security and privacy controls are in place for certain systems and software. For example, the OIG found that staff unnecessarily put employee personally identifiable information and veteran's personal health information at higher levels of risk when deploying the Veterans Data Integration and Federation Enterprise Platform (VDIF) and Mission Accountability Support Tracker (MAST). Due to ineffective oversight, OIT did not properly follow National Institute of Standards and Technology and VA policy requirements for setting VDIF's security controls at a high level. In addition, VBA and OIT did not correctly follow privacy and security procedures when governing MAST, in part because OIT misclassified MAST as an asset instead of a minor application. Minor applications require more security

controls than assets due to the sensitive nature of information they contain, such as personally identifiable information.

What VA Needs to Do

VA has launched several high-level action plans to address previously identified security weaknesses and the IT material weakness reported as part of the Consolidated Financial Statement audit. As part of these ongoing efforts, the OIG has noted improvements related to the following:

- Centralization of control functions
- Further maturation of the predictive scanning process and remediation of newer vulnerabilities
- New tools and software implemented to improve change management and the timeliness of background investigations
- Enhanced boundary protections and network threat-monitoring techniques
- Further enhancements and use of the centralized audit log collection and analysis tool

VA also needs to continue to address deficiencies that exist within access and configuration management controls across all systems and applications. Because of the issues with the consistent application of the security program and practices across VA's portfolio of systems, VA should have adequate control and risk management procedures applied to all their systems and applications to fully address previously identified weaknesses.

The OIG has called on OIT to take steps to make certain the appropriate security and privacy controls are implemented during the development of IT systems before they are hosted on VA's network. OIT should also follow through on implementing program management processes and protocols when establishing and monitoring security controls for IT systems.

While VA has made recent improvements on some aspects of information management and IT security, there remain considerable challenges. Secure IT systems and networks are essential to VA's fundamental mission of providing eligible veterans and their families with benefits and services. VA's information security program and its practices must protect the confidentiality, integrity, and access to VA systems and data. The recurrence of IT security concerns indicates the need for vigilance, and VA's incremental improvements are not enough to effect meaningful change. Until proven processes are in place to ensure adequate controls across the enterprise, VA's mission-critical systems and veterans' sensitive data remain at risk. Finally, major IT modernization efforts require careful planning and realistic timelines and budgets. This has been reported by the OIG as problematic for even much smaller endeavors VA has undertaken previously. The new electronic health record system discussed in the following section has been the subject of more than a dozen oversight reports and reveals challenges that are also often applicable to other major IT initiatives.

OIG CHALLENGE #5: LEADERSHIP AND GOVERNANCE

No initiative better reflects the intersection of the many major challenges VA faces than the implementation of the new electronic health record (EHR) system. Earlier OIG reports released on VA's efforts to deploy the new EHR detailed significant concerns with the initial deployment and staff readiness at the Mann-Grandstaff VA Medical Center in Spokane, Washington. More recent oversight has examined systems-level concerns and the effects on VA personnel, veterans, and VHA operations.

Most concerning are the issues the OIG identified that increase risks to patient safety. Deficiencies in data migration to the new system resulted in patients having inaccurate or incomplete medication lists in their records and made simple activities, such as refilling a prescription, more challenging. Initial data migration failures also affected the transfer of critical alerts within the patient record (flags) that identified veterans at high risk for suicide. "Disappearing" laboratory orders made diagnostic evaluations and treatment planning more difficult. Tools and processes for frontline system users to report concerns (including those pertaining to patient safety) and track the resolution of identified issues repeatedly failed. Frustrated staff stopped reporting issues and relied on workarounds to meet immediate needs, which was inefficient, sometimes bypassed security or safeguard measures, and increased the risk that known problems would remain unresolved.

The success of this monumental effort is put in peril if leaders are not responsive to the concerns of the clinical staff that navigate and rely on the functions of the EHR for everyday clinical decision-making. From October 24, 2020, through May 8, 2022, VHA staff reported 1,134 total patient safety events related to the new EHR. VHA's analysis has identified at least one catastrophic patient harm (death or major permanent loss of function) and two major patient harm cases (permanent lessening of bodily functioning). Patient safety issues must be prioritized and corrected as they are presented. Strong leadership is necessary to help navigate fatigued staff through the expected frustrations of adopting a new EHR.

Why This Is a Challenge

The critical role VHA serves in caring for veterans and in supporting our nation's healthcare systems underscores the need for the OIG's strong, independent oversight that has identified and reported on incidents and conditions in which quality of care and patient safety have been compromised, leaving veterans harmed or placing them at risk. The causes leading to these failings are often nuanced and multifactorial. However, common contributing factors the OIG has identified are poor, inconsistent, or ineffective leadership that cultivate a complacent and disengaged medical facility culture in which the VHA goal of "zero patient harm" is improbable, if not impossible.

A primary concern is governance: Is the right structure in place to identify potential issues to prevent their occurrence, to prioritize those issues that may affect prompt quality care to patients, and to resolve those issues before additional deployments? VHA experts must be heard and be fully engaged in the decision-making process to ensure medical facility personnel and patient concerns are adequately addressed. Another key concern is transparency. Is there transparency between the Electronic Health Record Modernization Integration Office, the facilities, VHA experts, OIT, and Oracle Cerner? Full and candid information sharing will help build confidence that issues are identified, prioritized, and adequately addressed. As VA prepares for future deployments in more complex facilities, proper governance, realistic timelines for addressing identified problems, and transparency with the public, Congress, and oversight bodies will be necessary to get it right. Failures in these areas risk cascading problems that put the entire program in jeopardy.

For example, between September 2020 and April 2021, the OIG experienced significant transparency challenges in receiving timely, complete, and accurate information during a healthcare review focused on employee training on the new EHR. While the OIG did publish a detailed report on the training program in June 2021, OIG staff had significant concerns about potential misconduct by two leaders of the then Office of Electronic Health Record Modernization's Change Management regarding their responses to requests for information about the plan to evaluate the training's effectiveness and data related to the post-training proficiency tests taken by employees. The OIG subsequently initiated an administrative investigation. While the investigation did not find that the two Change Management leaders intentionally sought to mislead OIG healthcare inspectors, the OIG found that their lack of due care and diligence resulted in inaccurate information being submitted to OIG staff.

What VA Needs to Do

Leaders across the enterprise must be intensely focused on patient safety at every interaction to mitigate these risks. The success of this EHR implementation is dependent on VA's transparency, fully developed planning, realistic and accurate timelines and budgeting, and recognition and remediation of patient safety and user concerns—not only identified by the OIG's oversight work but by VA's own experts and end users who navigate and rely on the functions of the EHR for everyday clinical decision-making.

The goal is to implement a modern platform that interacts with the network of providers and services within and external to VA and functions as a support tool for clinical and administrative staff to deliver safe and effective health care. Failure to acknowledge when a system presents obstacles to that goal and failure to immediately address those obstacles will expose patients to risk. Those failures also erode trust by the staff dedicated to delivering care and by the veterans who have been promised that care.

While implementation of the EHR is a dramatic example of challenges VA leaders will face in the next year and many years to come, other patient safety issues unrelated to IT systems persist that are more about people and processes.

In recent examples, leaders failed to address safety, staff, and environment of care concerns at the Tuscaloosa VA Medical Center in Alabama; quality of care concerns were cited at the VA Amarillo Healthcare System in Texas; multiple failures in test result follow-ups led to a delay in a patient's diagnosis of prostate cancer at the Hampton VA Medical Center in Virginia; and emergency department nurses failed to provide emergency care to a patient who arrived at the facility by ambulance at the Malcom Randall VA Medical Center in Gainesville, Florida. The patient later died. Leadership and governance were at the core of these failures.

VHA continues to face enormous challenges in providing high-quality care to the millions of veterans it serves. Despite these challenges, the OIG has witnessed countless examples of veterans receiving the care they need and deserve—delivered by a committed, compassionate, and highly skilled workforce. VHA staff have repeatedly overcome extraordinary obstacles to meet the complex needs of veterans. The OIG continues to emphasize the need for a cultural transformation within VHA, guided by accountable and attentive leaders that prioritize the safety of each veteran they encounter.

A change in organizational culture begins at the top. VA's under secretary for health needs to champion the changes that must be made to improve the culture within VHA. There must be close attention to the use of administrative punishments and rewards where patient safety issues are the subject of actions that were taken or should have been taken. There must be public celebration of those within VHA who do the right thing, and a consistent application of negative administrative action when shortcomings are identified.

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 above.

APPENDIX A: RELATED REPORTS AND CONGRESSIONAL TESTIMONY

See selected related reports below that support VA's FY 2023 Major Management Challenges. All VA OIG reports are available at www.va.gov/oig/.

Related Reports		Challenge #1	#2	#3	#4	#5
Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune	8/25/2022	X	X			X
Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure	7/21/2022	X	X			X
Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement	7/21/2022	X				
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022	7/7/2022	X				X
Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama	6/29/2022	X				X
Mission Accountability Support Tracker Lacked Sufficient Security Controls	6/22/2022		X		X	
Financial Efficiency Review of the VA El Paso Healthcare System in Texas and New Mexico	6/14/2022			X		X
Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions	6/8/2022		X	X		
Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight	6/6/2022	X				X
Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls	6/1/2022				X	X
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona	6/1/2022				X	X

Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas	6/1/2022				X	X
VHA Continues to Face Challenges with Billing Private Insurers for Community Care	5/24/2022			X		X
Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability	5/5/2022			X	X	X
Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois	5/3/2022	X				X
The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule	4/25/2022				X	X
Quality of Care Concerns and Leaders' Responses at the Amarillo VA Health Care System in Texas	4/14/2022	X				X
Federal Information Security Modernization Act Audit for Fiscal Year 2021	4/13/2022				X	
Noncompliant And Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities	4/7/2022	X				X
Inspection of Information Technology Security at the VA Financial Services Center	3/31/2022				X	X
Financial Efficiency Review of the Durham VA Health Care System in North Carolina	3/29/2022			X		X
Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints	3/24/2022	X				X
Independent Review of VA's Fiscal Year 2021 Detailed Accounting and Budget Formulation Compliance Reports to The Office of National Drug Control Policy	3/22/2022			X		

VA's Compliance with the VA Transparency & Trust Act of 2021	3/22/2022				X	
Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	3/17/2022	X			X	X
Public Disability Benefits Questionnaires Reinstated but Controls Could be Strengthened	3/9/2022		X			X
First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions	2/17/2022			X	X	
Audit of Community Care Consults during COVID-19	1/19/2022	X				X
MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data	12/20/2021	X			X	
Financial Efficiency Review of the Marion VA Medical Center in Illinois	12/16/2021			X		X
Financial Efficiency Review of the Eastern Oklahoma VA Health Care System	12/15/2021			X		X
VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services	12/8/2021			X		X
VHA Risks Overpaying Community Care Providers for Evaluation and Management Services	12/8/2021			X		X
Audit of VA's Financial Statements for Fiscal Years 2021 and 2020	11/15/2021			X	X	X
New Patient Scheduling System Needs Improvement as VA Expands Its Implementation	11/10/2021	X			X	X
Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon	11/9/2021	X				X
Successive VA Errors Created a $210,000 Debt for a Veteran with a "Service-Connected Mental Illness"	11/4/2021		X	X		

Related Congressional Testimony	Challenge #1	#2	#3	#4	#5
Statement of Julie Kroviak, MD, Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on "Close to Home: Supporting Vet Centers in Meeting the Needs of Veterans and Military Personnel" February 3, 2022	X				X
Statement of Deputy Inspector General David Case – Hearing on "Next Steps: Evaluating Plans for the Continuation of the Department of Veterans Affairs Electronic Health Record Modernization Program" April 16, 2022	X			X	X
Statement of Inspector General Michael Missal – Hearing on "At What Cost? - Ensuring Quality Representation in the Veteran Benefit Claims Process" April 27, 2022		X	X		X
Statement of Inspector General Michael Missal - Hearing on "Quality of VA's Health Care" May 11, 2022	X				X
Statement of Deputy Inspector General David Case – Hearing on "VA's Electronic Health Record Modernization Program" July 20, 2022	X			X	X
Statement of Deputy Inspector General David Case – Hearing on "Protecting Our Veterans: Patient Safety and the Electronic Health Record Modernization Program" July 27, 2022	X			X	X