STATEMENT OF DAVID CASE
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US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
"VA First, Veteran Second: The Biden/Harris Legacy"
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Chairwoman Kiggans, Ranking Member Ramirez, and subcommittee members, thank you for the opportunity to discuss the efforts of the Office of Inspector General (OIG) to enhance VA's accountability and aid in its continuous improvement. The OIG's mission is to serve veterans and the public by conducting meaningful independent oversight of VA's services, programs, and operations. OIG staff execute this mission by conducting accurate, fair, and impactful audits, reviews, healthcare inspections, and investigations across the nation. For fiscal year (FY) 2024, the OIG produced 316 oversight publications with 1,106 recommendations to VA for corrective action. Our personnel made nearly 250 arrests, fielded more than 34,000 contacts to our hotline, and testified before congressional committees on 14 occasions, as well as conducted nearly 200 briefings to members of Congress and their staff. Our work has resulted in a monetary impact of more than $6.8 billion for that 12-month period. This would not have been possible without the funding and other support we receive from Congress. We are also grateful to the veterans service organizations from whom we regularly solicit concerns and the many VA personnel and other stakeholders who bring to our attention a wide range of problems with VA programs and operations.

Integral to every OIG effort is intense scrutiny of the effectiveness of leadership and the quality management of VA operations that makes the most efficient use of taxpayer dollars. In a department the size of VA, with the nation's largest integrated public healthcare system, an aging infrastructure, and massive information technology (IT) modernization efforts, the OIG must remain vigilant to all risks to veterans, their families, and survivors. This requires the use of sophisticated data analytics and modeling; being responsive to hotline contacts and other allegations of misconduct; and rigorous and continuous oversight. OIG staff monitor programs and operations for breakdowns in processes; noncompliance with mandates; failures to provide quality health care; and deficiencies in the delivery of benefits and services. In addition, the OIG advances accountability by conducting an expansive range of administrative and criminal investigations that include, fraud, waste, and abuse of authority.

OIG leaders have testified before this subcommittee and other congressional committees many times in the past about enhancing accountability at VA.[1] There are several recurring themes and deficiencies that remain unchanged. These key elements of accountability are routinely identified by OIG staff and 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.

This testimony focuses on five components of accountability identified by the OIG as often lacking within VA programs and operations, and highlights several illustrative oversight reports:

1. Strong governance and clarity of roles and responsibilities
2. Adequate and qualified staffing to carry out those duties
3. Updated 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. Leadership that fosters responsibility for actions and continuous improvement

The OIG appreciates the work VA personnel—the vast majority of whom work under challenging conditions and are committed to continuous improvement—do every day on behalf of veterans. Despite these efforts, the OIG regularly identifies instances of misconduct, broken systems, confusing and conflicting governing policies or guidance, and inefficiencies or missteps in implementing programs. Given the importance of VA's mission, every individual at VA should feel a responsibility to identify and report risks and any resulting problems, and then take action to address the underlying causes and mitigate the chances for future occurrences. To underscore the need for personnel to report potential crimes and issues that put veterans, VA employees, and resources at risk, the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* recently codified the requirement that all new VA employees receive training on how to report and cooperate with OIG staff.[2] Ensuring employees and leaders understand their duty to report and remediate problems is meant to foster a culture of accountability across VA.

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 in part 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. Offices in administrations can be responsible for

[1] Recent OIG testimony to Congress can be accessed here.

[2] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118-210 § 501.

developing policy, but not for implementing or overseeing it. For example, financial officers in different administrations within VA do not report to the VA chief financial officer.

Two recent OIG reports serve as examples of how leaders did not act on known issues, resulting in delays in patients receiving health care. Last fall, the OIG published the results of a healthcare inspection regarding community care consult (referral) appointment scheduling practices. It examined delays for patients with serious health conditions who received community care through referrals from the VA Western New York Healthcare System in Buffalo.[3] The OIG found the system's community care staff did not timely schedule patients' radiation therapy and neurosurgery appointments, which resulted in delays in providing care and, in some cases, caused or increased the risk of patient harm. In particular, had there not been the delay in scheduling, and eventual cancellation of community care radiation therapy to treat a patient's cancer-related pain, efforts could have been made to alleviate that pain and improve the quality of life in the patient's final months. The Buffalo healthcare system and its community care leaders did not resolve the scheduling delays, despite advocacy by care providers and staff. The OIG found healthcare system leaders relied on inaccurate assurances from their community care managers that urgent, high-risk patient care consults were reviewed and prioritized, even as they received ongoing alerts about care concerns regarding those patients. The healthcare system and community care leaders' inactions were inconsistent with VA's stated commitment to the principles and values of high reliability organizations, as they failed to consistently focus on patients, get to the root causes of concerns, and predict and eliminate risks before causing patient harm. The OIG made two recommendations to the Veterans Integrated Service Network (VISN) director related to the healthcare system leaders' response to patient concerns and oversight of community care; and two recommendations to the Buffalo system's director related to establishing community care policies aligned with Veterans Health Administration (VHA) standards, as well as the disclosure of an adverse event (which has now been completed).[4]

Following an OIG analysis of VHA data, our healthcare inspectors reviewed the VA Loma Linda (California) Healthcare System's high use of community care providers for primary care, the impact, and system leaders' related oversight of VA outpatient clinics.[5] The OIG found that a new contractor responsible for the healthcare system's five non-VHA-operated community-based outpatient clinics experienced challenges staffing them. As a result, system leaders paused enrollment of new patients at all five of these clinics. VHA-operated clinics were unable to absorb the additional patients leading to an

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[3] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, September 27, 2024.

[4] VA has 18 VISNs across the nation—a regional network of care in which each VISN oversees VHA local healthcare facilities in their assigned area. An adverse event disclosure happens when a healthcare provider informs a patient or their family when a medical error or unexpected complication occurs during treatment that resulted in harm.

[5] VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*, April 23, 2024

increase in the system's use of community care providers for primary care. Further, the system's community care office was not able to timely process the consults and schedule community appointments. The OIG did not identify any patients who experienced poor outcomes as a result. However, the lack of a formal oversight structure for non-VHA-operated clinics, turnover in the system's leadership positions, and the new contractor together created a vulnerability in the management of primary care services provided at the system's clinics. The OIG's three recommendations to the system director are unimplemented at this time. They focus on monitoring primary care staffing and panel sizes (the number of patients assigned), timeliness of community care consult processing, and oversight of all the system's clinics.

ADEQUATE AND QUALIFIED STAFFING TO CARRY OUT DUTIES

Historically, VA has faced high vacancy rates across its programs and operations, especially within VHA. Shortages of qualified personnel in key positions have made it difficult for VA to carry out its goals and functions. Having the right people in the right positions committed to doing the right thing is essential to building workforce accountability, as is instilling that sense of responsibility in new hires.

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 annually identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center.[6] The FY 2024 review, the 11th and most recent that the OIG has conducted, found that 137 of 139 surveyed VHA facilities reported at least one severe occupational staffing shortage.[7] The total number of their reported severe shortages was 2,959, a 5 percent decrease from FY 2023, when facilities reported 3,118 total shortage occupations. Every year since 2014, the medical officer and nurse occupations have been identified as severe shortages, with the designations of medical officer as a severe occupational shortage generally decreasing since FY 2018. Following staffing increases in FYs 2022 and 2023, the nurse occupation was reported as a shortage by fewer facilities in FY 2024. Psychology was the most frequently reported clinical severe occupational staffing shortage in FY 2024, by 61 percent of facilities (85 of 139). Facilities also reported custodial worker and medical support assistance as the most frequent nonclinical shortage occupations, the same as for FYs 2022 and 2023.

An OIG review published last week highlights the impacts of insufficient staffing and hiring delays at the Joseph Maxwell Cleland Atlanta VA Medical Center's contact center for appointment scheduling.

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

[7] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2024*, August 7, 2024.

Callers experienced long hold times that led to abandoned phone calls.[8] Significantly, the facility's leaders were not attentive to concerning call center performance metrics, such as wait times and abandonment rates. The report also identified that the VISN had not been using available data to determine if its own call center was properly staffed.

In addition to addressing staffing shortages, VA should also ensure its existing personnel are equipped and prepared to do their jobs. The OIG has published numerous reviews over the last few years that examined whether staff at the Veterans Benefits Administration (VBA) were sufficiently trained for their duties.[9] For example, VBA uses the VA Schedule for Rating Disabilities (the rating schedule) to determine monthly compensation to eligible veterans for service-connected disabilities based on documented medical severity. In 2021, updates were made to the rating schedule for the musculoskeletal body system. The OIG performed a review to assess the effectiveness of VBA's implementation of the rating schedule changes for hip and knee replacements. The report on the review's findings, published in February 2024, found an estimated 38 percent of claims had an improper payment during the review period.[10] VBA paid an estimated $3.3 million in total improper payments for hip and knee replacement claims during that same period—including both underpayments and overpayments for these claims. VBA concurred with the OIG's four recommendations.[11] VBA has since provided sufficient documentation for the OIG to close its recommendations to supplement training on the rating schedule updates, including how to apply the changes to help ensure claims processors' comprehension.

The importance of a well-trained workforce to implementing VA's major initiatives cannot be overstated. Signed into law in August 2022, the PACT Act dramatically expanded access to VA health care and benefits for millions of veterans exposed to toxic substances.[12] The OIG assessed whether VBA

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[8] VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*, January 30, 2025. The three recommendations to the VISN director and the recommendation to the facility director are not yet implemented. The OIG will begin to follow up with VBA for progress on the recommendation's implementation on or about May 1, 2025. At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 30 calendar days to respond. Nothing precludes VA from providing interim progress reports.

[9] See, e.g., VA OIG, *Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, February 21, 2024; VA OIG, *VBA Needs to Improve Accuracy of Decisions for Total Disability Based on Individual Unemployability*, July 17, 2024; VA OIG, *Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits*, March 16, 2023; VA OIG, *VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims*, September 7, 2022.

[10] VA OIG, *Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, February 21, 2024. The OIG team reviewed a random sample of 112 in-scope claims from a universe of about 3,200 claims for convalescence for hip or knee replacements or resurfacing, received and decided from February 7, 2021, through August 31, 2022.

[11] There were two other recommendations that address issues unrelated to quality assurance and training.

[12] Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117-168.

staff processed PACT Act claims for presumptive disabilities in accordance with applicable laws and procedures before denying them—recognizing the potential impact on eligible veterans if claims were improperly denied. The OIG review team found errors resulting in unnecessary payments for examinations and medical opinions, as well as underpayments to veterans. A VBA leader told the OIG team that some claims processors said that information came at them quickly and there were too many changes. They further stated the implementation of PACT Act legislation was very challenging, but VBA did the best it could given the circumstances. In an interview, the former Compensation Service quality assurance rating review chief stated PACT Act guidance changed repeatedly after the initial rollout. Further, the chief stated VBA hired many new employees to process the most complex claims, which, combined with the changing guidance, may have caused confusion when regional office staff were working these claims and resulted in errors. VBA concurred with the OIG's two recommendations to update the claims processing manual to clarify when examinations and medical opinions are needed and to continue to develop tools to aid claims processors in determining when they are needed and to evaluate their effectiveness. The OIG has issued other reports on implementation of the PACT Act and will continue to monitor VA's implementation of the legislation.[13]

EFFECTIVE IT SYSTEMS AND BUSINESS PROCESSES TO SUPPORT QUALITY HEALTH CARE, ACCURATE AND TIMELY BENEFITS, AND EFFICIENT OPERATIONS

VA is modernizing numerous significant systems that are critical to its operations. However, as detailed in multiple proactive reports, the OIG identified breakdowns with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. VA's process for replacing crucial IT systems faces significant ongoing challenges. These have typically included weaknesses in planning, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. The results have been long delays, billions of dollars in over-budget costs, low user acceptance, and gaps in functionalities that make it more difficult for VA personnel to do their jobs. In some cases, the modernization efforts have put patients, beneficiaries, and resources at greater risk for harm or loss. The OIG understands the tremendous complexity of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working to ensure patient safety and to deliver benefits and services to eligible veterans, their families, caregivers, and survivors.

The Electronic Health Record Modernization (EHRM) program is probably the largest contract in VA history and critical to continued patient safety and care at VHA. Since April 2020, the OIG has released 22 oversight publications on VA's rollout of its electronic health record system that identify critical

[13] VA OIG, *VBA Provided Accurate Training on Processing PACT Act Claims but Did Not Fully Evaluate Its Effectiveness*, January 15, 2025; VA OIG, *Staff Incorrectly Processed Claims When Denying Veterans' Benefits for Presumptive Disabilities Under the PACT Act*, December 3, 2024.

missteps and lack of remediation.[14] Of the 93 recommendations issued to date, 32 have not yet been implemented—with eight open for more than 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 that could hinder the system from resolving major performance incidents and outages. Unless VA more effectively manages 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 lifted the June 2022 EHRM rollout pause, users of the new system continue to raise issues that the system hinders the delivery of prompt, high-quality patient care. Moreover, VA has not adequately addressed open OIG recommendations focused on the need to develop a reliable, high-quality schedule for future rollouts, in addition to the many other open EHRM recommendations. The effects on staff, workload, and the risks for errors are also concerning. In March 2024, the OIG reported that an error in the system led Columbus (Ohio) facility staff to not complete the minimum scheduling efforts following a missed appointment for a patient who later died by drug overdose.[15] The OIG team determined that for sites using the new electronic health record system, VHA required fewer patient contact attempts following missed mental health appointments. Essential to implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, integrated master schedule to ensure all tasks are properly accounted for and fully completed. A 2022 OIG audit found, however, that this foundational master schedule had significant weaknesses, including missing tasks, no baseline schedule, and no risk analyses, meaning VA cannot offer reliable assurances on timelines and costs.[16] That schedule has still not been completed at this time. The OIG will continue to conduct oversight on VA's plan to begin deployment operations next year in Michigan.

VA's delivery of education benefits to veterans is also tied to a new IT system. In 2024, the OIG reported on VBA's delays and increased costs in transitioning to the Digital GI Bill platform.[17] Unclear contract requirements and unrealistic expectations led to delays. In addition, the project's integrated master schedule was not updated consistently due to the lack of an overall schedule that tracked external dependencies. Poor communication between VBA and the contractor contributed to critical scheduling failures that caused delays and increased costs. VBA later renegotiated the original contract, more than doubling the cost to $932 million. The OIG made three recommendations, all as yet unimplemented, to the then under secretary for benefits to increase the chances of successful implementation under the new

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[14] OIG reports may be found on the website at All Reports. A list of EHRM reports can be found by searching on the key word "EHRM".

[15] VA OIG, *Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death*, March 21, 2024.

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

[17] VA OIG, *VBA Needs to Improve Oversight of the Digital GI Bill Platform*, August 28, 2024.

contract through improved monitoring, regular communication with the contractor to ensure a consistent and updated master schedule, and strategies to address critical path failures.

There are many other IT modernization efforts that are also interdependent and have had significant stalls, setbacks, or stops. These include financial and supply chain management—also the subject of myriad OIG oversight reports.

EFFECTIVE QUALITY ASSURANCE AND MONITORING TO DETECT AND RESOLVE ISSUES

VA often lacks controls that adequately and consistently ensure quality standards are met. Breakdowns in routine monitoring and the continual use of work-arounds undermine efforts to provide timely, high-quality services and benefits to eligible veterans and their families. Ineffective quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly in areas such as personnel suitability programs, credentialing, privileging, and monitoring of healthcare professionals entrusted with veterans' care.[18]

In September 2024, the OIG testified to this subcommittee and its full committee about issues at the Hampton VA Medical Center in Virginia.[19] For each of the last three years (2022–2024), the OIG published healthcare inspections of the Hampton facility that substantiated concerns related to clinical care.[20] In the most recent 2024 report, there were unaddressed clinical care concerns involving the

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[18] In March 2018, the OIG reported on deficiencies within the VHA personnel suitability program, concluding that neither VA nor VHA effectively governed the background investigation process to ensure requirements were met at medical facilities nationwide. VA OIG, *Audit of the Personnel Suitability Program*, March 26, 2018. In September 2023, the OIG reported on similar deficiencies during a follow-up audit of VHA's personnel suitability program. VA OIG, *VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement*, September 21, 2023. These prior audits identified issues that could affect the entire VA enterprise, prompting the OIG to audit the background investigation process for VBA and the National Cemetery Administration staff and determine whether investigation actions were completed on time and recorded reliably. The OIG determined there were problems at every step of the process, making four recommendations, all still open, to the under secretaries of benefits and memorial affairs. VA OIG, *VBA's and NCA's Personnel Suitability Programs Need Improved Governance*, September 30, 2024.

[19] VA OIG, Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, September 10, 2024; VA OIG, Statement of Jennifer Baptiste, MD, before the House Committee on Veterans Affairs, September 24, 2024.

[20] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, June 28, 2022 (multiple healthcare providers did not appropriately manage abnormal test results for this patient and staff and leaders did not initiate or submit patient safety reports or peer reviews); VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, September 29, 2023 (facility leaders were unaware until the OIG inspection and the facility lacked oncology care controls due to missing/ineffective cancer committee, tumor board, and cancer registry); VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

facility's then assistant chief of surgery.[21] The facility leaders at the time mishandled the processes for professional practice evaluations of surgeons, the surgical service's quality management, and institutional disclosures to patients or their representatives of an adverse event that resulted in harm. Facility leaders made numerous errors when determining whether changes were needed to the assistant chief of surgery's clinical privileges.[22] Leaders also did not report the assistant chief to the state licensing board. Failing to report providers may result in medical facilities within and outside of VHA hiring providers who do not meet generally accepted standards of clinical practice. These leaders also lacked a basic understanding of the quality assurance processes that support the delivery of safe health care. These three reports collectively uncovered issues with care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. The identified deficiencies contributed to increased risks to patient safety and adverse outcomes.

In their oversight work, what OIG healthcare inspectors find most troubling is when facility managers and leaders are either unaware of personnel and patient concerns or do not ensure the required quality management processes are carried out that would detect and correct them. High reliability organization principles foster a culture of "collective mindfulness," in which all staff look for and report small problems or unsafe conditions before they pose a substantial risk. If leaders are not aware of concerning singular events or more systemic challenges, they cannot ensure the appropriate steps are taken to safeguard patients. Implementing quality improvements to address specific patient safety issues requires open and honest communication from, and among, staff at every level of a facility.

LEADERSHIP THAT FOSTERS RESPONSIBILITY FOR ACTIONS AND CONTINUOUS IMPROVEMENT

The OIG published a report that was featured in congressional hearings and the national media on senior executives in VA's central office being improperly awarded $10.8 million in critical skills incentives authorized by the PACT Act. It uncovered weaknesses in VA's governance, leadership, and accountability, with excessive deference to both VHA and VBA leaders by individuals responsible for providing necessary checks and balances.[23] The PACT Act authorized VA to award critical skill incentives to only those staff who possessed a high-demand skill or skill that is at a shortage. As detailed in OIG testimony before this committee in June, officials at multiple levels across VA did not ensure their actions met the requirements and intent of the law and did not successfully escalate concerns to

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[21] VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

[22] Clinical privileging is defined as the process by which a VA facility authorizes a physician to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis. Clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

[23] VA OIG, *VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives*, May 9, 2024.

then Secretary McDonough.[24] VA concurred with the OIG findings that the awards were inconsistent with the PACT Act and VA policy and that VA's internal controls were ineffective to prevent the improper awards. The OIG continues to monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

Other oversight work has revealed that VA leaders at every level often do not get the information they need to make effective decisions. Some also do not take necessary and prompt action, while others struggle to create a workplace in which every employee feels they can and should report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

In 2024, the OIG released three reports on the VA medical facility in Aurora, Colorado, also describing the kind of accountability failures that every facility leader should be vigilant in preventing. The OIG's first report found that key senior leaders created an environment in which a significant number of clinical and administrative service and section leaders and frontline staff felt intimidated, deeply disrespected, and dismissed.[25] For example, staff feared that speaking up or offering a difference of opinion to the Peer Review Committee would result in reprisal. In a second report, an OIG team substantiated that leaders' actions to change the facility's intensive care unit from an open to a closed model (affecting which providers had patient care responsibility) were made without adequate planning and input from relevant leaders and staff. [26] These problems were allowed to persist because VISN leaders did not fulfill their own required oversight of the medical center.[27] The third report found that telemetry medical instrument technicians were not properly monitoring patients and that staff did not properly enter a Joint Patient Safety Report following a patient's death.[28]

As to work that is forthcoming that illustrates the OIG's commitment to enhancing VA accountability, OIG teams are finishing work on the conditions and contributing factors to the FY 2024 supplemental request by VBA and the multibillion dollar shortfall in VHA's budget for FY 2025.[29] In accordance with

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[24] VA OIG, Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, June 4, 2024.

[25] VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024. One of seven recommendations has been closed.

[26] VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, June 24, 2024. All recommendations remain open.

[27] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks that oversee the medical facilities in their designated area.

[28] VA OIG, *Failures by Telemetry Medical Instrument Technicians and Leaders' Response at the VA Eastern Colorado Health Care System in Aurora*, August 13, 2024. Five of the six recommendations remain open.

[29] According to the budget submission dated March 2024, VHA initially estimated needing about $149.5 billion to care for patients in fiscal year (FY) 2025. However, by July 2024, VHA estimated that it would need an additional $12 billion in FY 2025 for medical care. By November, that request was modified to $6.6 billion.

the governing statute, the OIG will publish these reviews before March 19, 2025.[30] VA's ability to accurately forecast its administration and staff office budgets, and then properly execute appropriated funds, is dependent on adhering to the foundational elements of accountability.

CONCLUSION

The OIG has experienced 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 leadership that fosters responsibility for actions and continuous improvement. The OIG strongly encourages VA personnel at every level to lead by example and escalate matters that put veterans' health and welfare at risk, undermine VA's services and operations, or waste taxpayer dollars.

Chairwoman Kiggans, Ranking Member Ramirez, and members of the Subcommittee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance VA's delivery of care and services to veterans, their families, and caregivers. I would be happy to answer any questions you may have.

[30] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act, 2024, Pub. L. No. 118-92 § 104.