OTHER INFORMATION

VA researchers use novel approach to gain insight into suicide risk factors

Picture previous page: Dr. Robert Graziano, the lead researcher on the study, received support from the Mid-Atlantic Mental Illness Research, Education and Clinical Center at the Durham VA.

Predicting suicide has long been one of the most researched subjects in psychology. One of the key conclusions is that suicide has many risk factors and it's hard to pinpoint how those factors relate to one another.

Dr. Robert Graziano, a postdoctoral Fellow in clinical psychology at the Durham VA Health Care System in North Carolina, led a study on the risk factors among Iraq and Afghanistan Veterans for suicidal ideation. His study used an emerging approach in mental health research called network theory. The main purpose is to illustrate how a series of variables - in this case risk factors for suicide - relate to each other and which are the most important, thus addressing a major shortcoming of other methodologies.

Graziano's team found suicidal ideation to be strongly related to depression, with small connections to past suicide attempts and anger. Previous suicide attempts were strongly related to the history of childhood trauma and weakly related to illegal drug use and post-traumatic stress disorder (PTSD). "These results offer valuable information for both predicting suicide risk and differentiating targets for interventions lowering suicide risk in Veterans," said the researchers. The findings appeared in the Journal of Psychiatric Research in April 2021.

Graziano's study isn't the first one to use network theory to look at suicide. But he believes only one other study—research led by Dr. Jeffrey Simons of the Sioux Falls VA Health Care System in South Dakota—used network theory to examine suicide risk factors in the Veteran population.

Graziano's work built on Simons' study by looking at series of additional important risk factors related to suicide risk. Simons' study included trauma exposure, PTSD symptoms and depression, but Graziano added past suicide attempts, substance abuse, anger and sleep quality. Including those additional risk factors allowed Graziano and his team to look at a larger set of potential links related to suicide risk.

Network analysis is based on the factors included in the models, but researchers are often limited by what is available in their data, Graziano explains. His study had a relatively large sample size of 2,268 Veterans, which has historically been a limitation in studies using network theory. The data were collected via surveys and have been used in many other studies. Without a large sample size, he notes, a researcher can't include a lot of risk factors and expect to create a stable, accurate network. Simons' study included 276 Veterans.

Suicide prevention is VA's top clinical priority. VA's 2020 National Veteran Suicide Prevention Annual Report notes that in 2018 - the most recent year for which data are available - the total number of Veterans who died by suicide increased less than one percent compared to the prior year to an average of 17.6 per day.

VA Research Currents conducted a full interview with Dr. Graziano, which can be read online.

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

FOREWORD

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, and the public by conducting effective oversight of Department of Veterans Affairs (VA) programs. The OIG recommends enhancements to VA services, operations, processes, and systems that will improve the lives of veterans and make the best use of taxpayer dollars. Each year, the Inspector General provides an annual update to VA summarizing the 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 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 that VA must navigate in the fiscal year ahead have been identified by OIG personnel, other external oversight agencies and organizations, the veteran community, Congress, and additional stakeholders. They reflect the OIG's unwavering commitment to veterans, their families, and caregivers, and the VA leaders and staff who serve them.

As we are well into the second year of the COVID-19 pandemic, our thoughts are with the families of the more than 15,000 veterans and over 225 VA employees who have died as a result of the virus. The OIG lauds the efforts of the numerous VA employees who have worked to treat and comfort veterans, their families, and caregivers. We also recognize the other efforts by VA personnel to address the many challenging situations caused by the pandemic, including working to assist communities in need across the nation. They have done so at significant personal risk. In addition, the OIG recognizes the many VA staff who have found innovative solutions to continue providing benefits and services during these challenging times.

MICHAEL J. MISSAL
Inspector General

OIG CHALLENGE #1:

Veterans and their families entrust their lives to VHA medical providers and staff every day at the more than 1,200 VHA facilities. They expect and deserve the highest quality of care delivered in a safe and accountable healthcare setting. Fundamental to providing this level of care is creating an environment where patient safety is the highest priority of all staff at every patient interaction, and any perceived compromises to that safety are reported and thoroughly evaluated.

This past year, the OIG has reported on high-profile instances in which facility leadership did not consistently promote a culture that prioritized patient safety as expected of a high reliability organization. Consequently, a combination of clinical and administrative failures created conditions that put patients at risk and, in some instances, allowed for the carrying out of horrific crimes against some veterans.

Among the worst, a former nursing assistant pleaded guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder of veterans at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. The former nursing assistant pleaded guilty to deliberately administering insulin to these patients in 2017 and 2018, resulting in profound hypoglycemia and death.

The OIG reviewed the events surrounding the homicides to understand how such actions could have occurred, whether they could have been detected earlier, and what actions should be taken to prevent future tragedies. The OIG found that the facility had serious, pervasive, and deep-rooted clinical and administrative failures that contributed to the criminal actions not being identified and stopped earlier. The failures occurred in virtually all the critical functions required to promote patient safety and prevent avoidable adverse events at the facility.

Also this year, the OIG completed its inspection related to allegations that a doctor within the Pathology and Laboratory Medicine Service at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was misdiagnosing patients' pathological specimens and altering quality management documents to conceal his errors. It was also alleged that a facility leader did not adequately monitor the doctor's clinical practice and failed to address misconduct.

After the doctor admitted to the OIG of a 30-year problem with alcohol and the more recent use of a substance with similar effects, but not detectable by routine testing, the OIG grew concerned about facility staff having observed signs of impairment earlier than 2016 but not formally reporting them as required. For example, a patient was diagnosed with lymphoma when the patient actually had a small-cell carcinoma. The doctor covered his tracks by falsifying the patient's medical record. The patient later died due to misdiagnosis that resulted in the failure to have appropriate treatment.

When interviewed, staff who observed impaired behaviors shared concerns about reporting, including fear of reprisal. An administrative investigation board was initiated in 2018 and evaluated the facility's culture related to quality and safety reporting. The administrative investigation board found a lack of transparency in the pathology quality management processes and communication delays. The OIG determined that facility leaders did not foster a

culture of accountability to staff. The OIG concluded that facility leaders did not meet VHA's goal to establish an "environment in which staff act with integrity to achieve accountability."

Why This Is a Challenge.

In every hospital, patients are exposed to known risks that are often inherent to that environment. Ultimately, quality health care is dependent on leaders who promote a culture of safety that reduces or eliminates those risks whenever possible. Providing high-quality health care to a diverse and complex patient population demands the support of, and adherence to, an organization-wide culture of safety. When this occurs, a patient-centric environment becomes the "norm."

Conversely, systemic weaknesses in a facility's culture of safety can have devastating consequences. The choices providers make in the delivery and management of health care may result in unintentional poor quality outcomes. An honest, open discussion of these poor outcomes is difficult and, at times, places extreme stress upon the personal and working relationships that exist within the healthcare system. Nevertheless, they must occur. The OIG's reports continue to highlight examples of significant compromises to patient safety that persisted over extended periods of time without meaningful interventions or actions to correct and ultimately prevent patient harm.

What the Department Needs to Do.

The failure to create an environment where clinical staff and facility leadership work in concert to address unusual and unexplained patient deaths is an indication of the need to reconsider all aspects of VA's patient safety program. A failure of facility leaders to vigorously explore or take action may promote perceptions that reporting will have no effect. Not aggressively addressing reports of safety issues can also discourage staff from complying with the facility's policy to report observations of possibly unsafe treatment. VA leaders need to instill in all employees the understanding that patient safety is ultimately a consequence of accountability, adherence to protocols that prioritize high-quality care, and a shared responsibility among all who participate in that care to recognize and report any perceived compromises to that safety.

Finally, VA needs to (1) review the data collected as the basis for evaluation of patient safety within facilities, (2) complete the roll-out of VA's High Reliability Program, (3) create a culture where honest discussions of difficult problems is encouraged and is the result of collaboration with VHA stakeholders, and (4) consider wider use of clinical case management rounds where difficult cases are objectively reviewed and alternative decision possibilities are discussed in an open provider patient safety forum.

OIG CHALLENGE #2:

Eligible veterans, their families, and caregivers must receive proper benefits and services in a timely manner. VBA has faced significant challenges as the result of the necessity of limiting in person exams during the pandemic to keep veterans and personnel safe while at the same time minimizing benefit claims processing delays and ensuring claims are not prematurely denied due to missed or canceled in-person exams.

In the next fiscal year, staff will need to continue to navigate safety measures while working through the identified backlog of medical examinations, claims, and other matters, all while balancing ongoing demands. The pandemic's effect on education, training, and the economy has been felt by veterans nationwide who have applied for a wide range of benefits. Similarly, the demand for healthcare benefits is expected to remain high.

The OIG has made a range of recommendations that will need to be implemented through the coming fiscal year to advance expeditious and accurate VBA decision-making and processes for delivering benefits.

Challenges include addressing previously identified recurring deficiencies such as inadequate planning for systems or process changes; mismanagement of backlogs; vague guidance for disability claims medical examinations processing and disability claims decisions; unclear definition of roles and responsibilities for local or regional oversight; lack of controls; and limited information technology functionality, which contributes to inefficiencies and inaccuracies.

As a result of these recurring issues involving VBA's processes, compounded by COVID-19 demands, staff have significant challenges ahead maintaining the accuracy and timeliness of essential claims and conducting appeals-related activities.

Why This Is a Challenge.

OIG reports have often identified significant challenges in VBA's attempts to deliver accurate and timely claims decisions and appeals. Failures in timeliness, guidance, training, quality assurance, and systems have been well-documented, especially with regard to particularly complex claims, such as those involving conditions of the spine with secondary service connected conditions.

More recent OIG reports have identified the need for VA to enhance its strategy to reduce the disability exam inventory due to the pandemic and to reduce errors related to canceled exams. During a period of discontinued in-person exams, the OIG found that some claims were denied prematurely or improperly, based on notifications in VBA electronic records showing the veteran did not report for an exam, or the exam was canceled at the veteran's or VA's request. VBA later assured veterans that no final action—including the denial of claims—would be taken on claims when an in-person exam was needed. However, based on the results of the OIG review, continued oversight of premature or improperly denied claims is needed to ensure appropriate action has been taken. Finally, VBA must further develop and test its strategy to reduce the growing inventory and incoming exam requests.

The MISSION Act focus on the delivery of more community care has also taxed VA processes and procedures, and the OIG has reported on mismanaged appeals of non-VA care claims and non-VA emergency care claims.

Finally, VA must also continue to address increased claims following the implementation of the Blue Water Navy Act of 2019 on January 1, 2020, which extended the presumption of herbicide exposure, also known as Agent Orange exposure, to nearly 90,000 veterans.

What the Department Needs to Do.

As VA continues to manage the effects of the pandemic on its facilities and staff, safety measures have been put in place and protocols have been communicated. Veterans have become less hesitant to report for in-person exams, and VA has steadily increased the number of compensation and pension exams it has processed.

The OIG has reported that VBA took a number of positive and decisive actions in response to the COVID-19 pandemic. However, VBA continues to need to enhance its strategies to help reduce disability exam inventory and backlog related to pandemic restrictions and take additional steps to address errors related to exam cancellations. Greater oversight is needed to ensure VA personnel and contractors comply with policies and procedures in examinations.

The OIG has made many recommendations in recent years related to improving the accuracy and timeliness of VBA's claims decisions and appeals processes. VA has implemented and encouraged more training at the local levels to better complete assigned roles.

Finally, VBA must further develop, implement, and test its strategy to reduce the growing inventory of pending exams, while handling incoming exam requests. The plan must incorporate lessons from COVID-19 to ensure continuation of exam processing and prepare for future pandemic surges and other national emergencies. A detailed and tested strategy that draws on all its partners and resources will help VBA reduce the risk of further delaying veterans' claims or denying them the benefits they are due.

OIG CHALLENGE #3:

The OIG has consistently identified procedures and strategies for improving the responsible use of VA-appropriated funds, including sound and closely monitored procurement practices and the need for internal controls. When funds are wasted or misused, valuable resources are diverted from benefiting veterans, their families, and caregivers.

VA continues to have 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 undue reliance placed on manual processes to identify or correct errors with financial information.

These chronic reporting weaknesses have been highlighted much in the past, and also in recent OIG work as it examined VHA's reporting of the billions of dollars in pandemic-related relief funds provided by Congress.

While the OIG found that VA met its congressionally mandated reporting requirements for the pandemic-related relief funds, the OIG noted three concerns that affected the completeness and accuracy of VA's reporting to the Office of Management and Budget and Congress. First, obligations were at risk of not being included in VA's reports; second, VA initially delayed the reporting of reimbursable obligated amounts for two months; and third, VA's reports contained anomalies (negative dollar amounts in data fields that should only have positive amounts, which misstated VA's overall reported obligations).

The OIG believes that due to VHA's reliance on several accounting subsystems for payroll and purchase card transactions, VHA staff had to perform a significant amount of manual work to identify and perform adjustments so that the COVID-19 obligations and expenditures were captured in VA's reporting. The overall complexity of VHA's reporting process indicates that controls around VA's data reporting and validation efforts can be improved.

The OIG has repeatedly identified costs due to delays or mismanagement of IT systems. Tax dollars have also been wasted or misused because of a lack of internal oversight and poor planning within programs. The pandemic has stressed systems further and required that some controls be circumvented to adjust to emergency conditions. While certainly understandable, the impact has created additional challenges for VA that will be felt for some time.

Why This Is a Challenge.

VA's size and complexity of operations make effective budget management extremely challenging. VA's financial management system is over 30 years old and has functional limitations well-documented in OIG reports. The complex and disjointed architecture of the financial management system creates difficulty meeting increasingly demanding financial management and reporting requirements. VA continues to be challenged in consistently enforcing established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

As reported in the most recent Semiannual Report to Congress, the Federal Financial Management Improvement Act (FFMIA) requires all agencies covered by the Chief Financial Officers Act to implement financial management systems that substantially comply with three essential requirements: (1) federal financial management systems requirements, (2) federal accounting standards, and (3) the United States Standard General Ledger at the transaction level.

The audit of VA's financial statements for fiscal year 2020 continued to report instances where VA's financial management systems did not substantially comply with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under FFMIA. These findings have been repeatedly reported in part for more than 10 years.

Also, VA did not fully comply with the intent of the Federal Managers' Financial Integrity Act due to internal control weaknesses identified and because improvements could be made in VA's testing of internal controls.

The pandemic is intensifying these long-standing challenges and delaying initiatives intended to remediate these problems, including financial management reforms and the transformation of business processes. While VA has numerous initiatives to curb fraud, waste, and abuse, the pandemic is creating novel opportunities for bad actors, and has left VA vulnerable to various fraud schemes, including contract and procurement fraud, bribery and kickback schemes, and internal issues such as employee theft and the improper reporting of overtime.

Even before the pandemic, the OIG investigated hundreds of instances of fraud, bribery, theft, and False Claims Act violations, resulting in judicial actions that involved hundreds of millions of

dollars in VA monetary benefits. The most recent Semiannual Report to Congress reported investigative actions that impacted $1.02 billion in monetary benefits.

What the Department Needs to Do.

VA has made progress on correcting certain control deficiencies pertaining to financial reporting, and VA is in the process of deploying a new financial system in a series of phases over an extended period of time.

Compliance with VA policies remains essential even in emergency situations. As the Information Systems and Innovation section discusses below, delays and changes in implementing new systems have implications for effective financial management that can only be addressed through comprehensive and coordinated planning.

OIG CHALLENGE #4:

The challenges associated with information systems and innovation strongly affect VA's ability to conduct its programs and services. The provision of timely and quality health care and benefits for veterans and other eligible individuals depends in large part on the security functionality, effectiveness, and ease of use of underlying systems. The OIG has amassed a large number of reports and recommendations that assess and propose enhancements to VA's infrastructure systems, including IT and data security. Through findings and report recommendations, the OIG highlights practices that promote quality standards that can be implemented throughout VA, particularly those that effectively use program planning, budget forecasting, and other predictive tools.

For example, the OIG has identified multiple systems that lack the functionality or proper controls to ensure that large backlogs, errors, inefficiencies, and obstacles to information sharing are minimized or redressed. Some challenges center on the planning and execution of new IT systems and transitioning from legacy systems, while others also involve patterns of user abuse or mistakes that can go largely undetected for long periods. Changes to mission critical systems and infrastructure network devices did not always follow standardized software change control procedures, and infrastructure was not always upgraded timely in order to bring facilities up to VA and industry standards. Decentralized oversight, unrealistic timelines, inadequate engagement of all stakeholders and end users, and minimal testing for some systems have plagued IT projects. The OIG has detailed recurrent issues that run through reports on the GI Bill implementation, changes to systems affecting benefits to eligible veterans, payments for care in the community, medical supply and equipment inventory, financial management, electronic healthcare waiting lists, and police information management.

Perhaps the most visible and challenging of these is VA's Electronic Health Record Modernization (EHRM) program, one of the largest IT projects in government history. VA is nearly three years into replacing its aging electronic health record system. The OIG has been conducting early oversight of VA's efforts because of the tremendous cost and scale of the effort and its impact on veteran health. In addition to the almost $10 billion contract, VA estimates another $6.1 billion will be needed for program management and infrastructure-related costs. Of this amount, approximately $4.3 billion is for program infrastructure and the remaining $1.8 billion is estimated for program management. However, recent OIG work has found that the

estimate of $4.3 billion was not reliable. Furthermore, the OIG determined that VA did not report to Congress other, critical program-related IT infrastructure upgrade costs totaling about $2.5 billion as well as physical infrastructure upgrade costs totaling about $2.7 billion.

In addition to EHRM, VA is working to implement the Defense Medical Logistics Standard Support (DMLSS) System as a solution to an inefficient, poorly functioning $10 billion supply chain. The VA Logistics Redesign Program Office's goal is to implement the DMLSS System to modernize VA's supply chain, establish an integrated IT system to support business functions and supply chain management, and address the system's many identified supply chain deficiencies. The OIG has ongoing work to examine these efforts.

Finally, VA has also begun implementing the Integrated Financial and Acquisition Management System (iFAMS) to replace its legacy financial and contracting IT systems of record. The new system is expected to deploy across the VA enterprise through calendar year 2027. This replacement is critical because continued reliance on the Department's legacy financial system presents enormous risk to VA operations. The OIG has ongoing work to evaluate the first phase of this system's deployment.

Why This Is a Challenge.

Challenges to implementing new technologies across a decentralized and complex system are numerous. For example, unrealistic deadlines and inadequate planning are symptomatic of trying to be responsive to identified needs and demonstrate progress without addressing identified and emerging problems. Shortcuts often result in costly delays and complications.

For EHRM implementation VA-wide, challenges are intensified by VA's need to coordinate and collaborate internally as well as with DoD, and to modernize VA's aging infrastructure to accommodate the new system. OIG reports demonstrate failures in oversight, planning, and coordination, and VA has temporarily halted plans for EHRM implementation.

The recommendations from our five reports published between April 2020 and July 2021 are meant to help VA make modifications to its roadmap for future implementation efforts. The OIG has repeatedly found issues with this deployment including deficiencies in infrastructure readiness at the first VA facility to use the new system and stove-piped governance with decision-making that does not appropriately engage VHA personnel who are the end users of the new EHR system. The OIG also found that the risk mitigations facility leaders would employ during the planned go-live period were inadequate to address the gaps in capabilities and presented a potential, yet significant, risk to patient safety.

As with EHRM, interoperability with VA systems and holistic changes to business processes continue to be significant hurdles to VA's implementation of the DMLSS System.

What the Department Needs to Do.

The long-standing and repeat areas of weakness identified in VA technology projects require across-the-board improvements in project planning, scheduling, the calculation of associated costs, user and stakeholder engagement, leadership, security, and infrastructure enhancements, and other areas where the OIG has repeatedly recommended corrective actions.

The OIG recognizes the significant level of effort and commitment required by VA to manage and facilitate the implementation of the massive and complex electronic health record system, including the tremendous work already conducted by VA staff. In part due to the OIG's work, VA has already taken actions to improve the reliability of its estimates.

VA should continue strengthening its cost-estimating procedures to ensure all characteristics of a reliable estimate are consistently and fully met. VA should also continue to reassess the enterprise-wide deployment schedule to ensure projected milestones are realistic and achievable, and that training is effective and evaluated. Failure to redress identified issues puts VA at risk for additional failures, breakdowns, and delays when deploying the new electronic health record system nationwide in the years to come.

OIG CHALLENGE #5: LEADERSHIP AND GOVERNANCE

A common theme across recent OIG reporting has been the prevalence of a culture of complacency. By this it is meant that there were staff who either felt it was futile to report problems or were concerned that they would be retaliated against if they did report. Some of the more significant failures include the murders of veterans at the Clarksburg VA medical center; the Arkansas doctor who continued to report for duty while intoxicated (both mentioned in challenge #1); and unreported misconduct by a gynecological provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi. A non-healthcare example includes VA staff knowingly failing to refund hundreds of millions of dollars in home loan funding fees to disabled veterans.

A leadership culture that does not seek to support transparency, oversight, and accountability will often fail to put veterans first when faced with external pressures. This was evident in the OIG investigation into senior VA officials' response to a veteran's sexual assault allegations at the Washington, DC, VA Medical Center wherein the OIG concluded that the then-VA Secretary failed to meet the agency's most basic mission of providing care and to consider the safety and welfare of veterans. The OIG found that former senior VA officials questioned the veteran's credibility and motive after learning of her complaint. Later, the former senior VA officials publicly cast doubt on the veteran's credibility by mischaracterizing the allegations as "unsubstantiated." The OIG's investigation was also hindered by the refusal of several former senior VA officials to cooperate with request for follow-up interviews to clarify and resolve conflicting evidence.

Why This Is a Challenge.

VA has many dedicated leaders who are committed to providing the best possible services to veterans, often under very stressful conditions. However, many emergent problems have arisen, and some problems that are pervasive and persistent have gone unaddressed because of frequent turnover or vacancies in key positions and failures in leadership, including lack of accountability, poor governance, and misconduct by individuals in positions of trust. The challenge of maintaining stable and effective leadership cuts across all areas of concern previously discussed. The OIG has identified frequent changes (and lapses) in leadership and workforce or staffing issues as major management challenges to VA in providing veterans with timely access to quality care.

Across VA, previous OIG reports have shown that leadership environments were not effective in recruiting and retaining the talent required. In fact, in our hotline reports and Comprehensive Health Care Inspection reports, it is common to see many leaders placed in acting positions throughout VHA. VA has experienced chronic shortages of healthcare professionals since at least 2015. VA's inability to adequately recruit, onboard, and retain clinicians and support staff, particularly in specific service areas, reflects problems with competitive pay, widespread shortages in some professions or positions, unfavorable leadership and work climate, inadequate planning, and other factors.

Finally, VA governance and oversight is often decentralized. Oftentimes, there are multiple offices that oversee aspects of a particular initiative or function within VA. The policy office may, for example, develop guidance or even training, but oversight, quality control, and staffing may be handled by others. Oversight roles and duties are often misunderstood, and guidance may be vague, conflicting, or simply in too many different places to navigate. Information critical to operations may not be well-documented, shared, or used for decision-making.

What the Department Needs to Do.

VA needs to promote a culture of accountability. Leaders need to take on persistent problems and establish clear lines of authority that promote accountability for accuracy, efficiency, and effectiveness in carrying out responsibilities. This includes supporting the OIG's oversight mission, complying with requests for interviews and information, providing accurate and timely information, and responding to recommendations. The current VA Secretary has taken steps to improve communication and cooperation in support of the OIG's oversight mission, including supporting training developed by the OIG for VA employees to educate staff on the OIG mission and authorities.

VA needs to work to create a stable leadership group that is experienced in delivering the high quality benefits that veterans deserve. The Department needs to continue its efforts to hire quality talent, pay competitive wages, and place value in technical competence and proven leadership.

VA has increased the transparency and utility of its staffing and vacancy data by adding elements to its reporting, such as summary and historical information. However, VA still needs to work on the quality and transparency of position data to achieve full staffing capacity and identify the additional funds needed to achieve it. More action is needed to ensure that vacancies and employee gains and losses are reported accurately and comply with legislative requirements.

VA Management's Response

VA acknowledges the five challenges presented in the OIG report and appreciates the IG's dedication to identifying opportunities for improvement in VA programs and operations. VA management is committed to implementing corrective action plans developed in response to each of the five challenges.

Challenge #1: Healthcare Services - VA has learned a great deal from OIG's findings and will use them to understand where we can improve. As an organization dedicated to high reliability, we strive to promote employee willingness to raise concerns and to build robust systems for investigation around unusual or unexpected deaths.

To ensure adequate controls are in place, VA established an interdisciplinary work group to review high alert medication safety, storage and security across VA and conducted an audit of medication storage areas at all local medical centers. The audit found that 95% of 8,859 medication storage areas were kept locked. All facilities not meeting 100% of all medication storage areas locked are developing action plans for improvement.

Challenge #2: Benefits for Veterans - VA expects the claims backlog to rise due to the court ordered *Nehmer* re-adjudication and the implementation of three new presumptive conditions established in the FY 2021 National Defense Authorization Act; however, VBA plans to reduce the claims backlog to 100,000 by the end of FY 2023 through collaboration with medical exam contractors, VHA and Federal records partners. In FY 2022, VBA will establish the Office of Review, Compliance and Accountability, to promote continuous improvement, sustainability of actions taken and fewer repetitive findings.

Challenge #3: Stewardship of Taxpayer Dollars - VA continues to implement corrective actions through a major improvement initiative to replace and modernize the antiquated systems. This effort will increase the transparency, accuracy, timeliness and reliability of financial information, resulting in improved financial controls and fiscal accountability to American taxpayers in accordance with FFMIA. The Department is leveraging lessons learned during recent deployments of the new financial system at NCA and VBA to evaluate and adjust our strategy moving forward.

Challenge #4: Information Systems and Innovation - While the key findings of VA's EHRM strategic review largely match those of the OIG, the Department remains committed to the Cerner Millennium solution and the EHRM implementation has not been halted.

Challenge #5: Leadership and Governance - VA is working to address challenges with mission critical gaps through the implementation of more robust workforce management analytical capabilities to assess staffing requirements and the development of tools and policies to fill staffing gaps in a timely manner. These strategies are supported by a range of efforts to include: continued direct hiring authorities, recruitment and retention flexibilities and incentives; hiring initiatives; virtual trainee recruitment events; improved employee engagement; human resources modernization; workforce planning; targeted recruitment of military spouses and Service members transitioning from the Department of Defense (DoD); national recruiter programs for hard-to-fill occupations and specialties; and strategies for filling Medical Center Director (MCD) positions throughout VA. These strategies aim to reduce time to hire and loss to competition by using standard position descriptions, non-competitive authorities, reducing onboarding time and offering more workplace flexibilities.

To support oversight, VA will provide staff with a web-based training module titled, "Meeting Responsibilities to Report Misconduct and Promote VA Efficiency and Effectiveness". The training will provide clear roles, responsibilities and OIG legal authority. This training is designed to ensure VA employees understand the engagement protocol with OIG staff to improve VA programs, operations and services through proper and accurate reporting of fraud, waste, abuse and other complaints associated with OIG's responsibility area.

For additional information regarding major management challenges and how VA is working to address each one, please follow the links to related reports and testimony on page 169-170.

RELATED REPORTS:

Selected related reports from fiscal year 2021 (with a comprehensive list of publications available at www.va.gov/oig):

Related Report	Challenge #1	Challenge #2	Challenge #3	Challenge #4	Challenge #5
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	X				X
Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	X				X
Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas	X				X
Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens	X				X
Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio	X				X
Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations	X				X
Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams		X			X
VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors		X			
Improvements Still Needed in Processing Military Sexual Trauma Claims		X			X
VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits		X			
Audit of VA's Financial Statements for Fiscal Years 2020 and 2019			X	X	
Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020			X		
Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations			X	X	
Review of VHA's Financial Oversight of COVID-19 Supplemental Funds			X	X	X
Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington				X	X
Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program				X	X

Related Report	Challenge #1	#2	#3	#4	#5
Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program				X	X
Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records				X	
Program of Comprehensive Assistance for Family Caregivers: IT System Development Challenges Affect Expansion				X	
Related Congressional Testimony					
Statement of Deputy Inspector General David Case, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Technology Modernization, U.S. House of Representatives, Committee on Veterans' Affairs, Hearing on Moving Forward: Evaluating Next Steps for the Department of Veterans Affairs Electronic Health Record Modernization Program	X		X	X	X
Statement of Deputy Inspector General David Case, Office of Inspector General, Department of Veterans Affairs, Before the U.S. Senate Committee on Veterans' Affairs Hearing on VA Electronic Health Records: Modernization and the Path Ahead	X		X	X	X
Statement of Michael Bowman, Office of Inspector General, Department of Veterans Affairs, Director of IT and Security Audits Division, Before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, U.S. House of Representatives, Hearing on Cybersecurity and Risk Management at VA: Addressing Ongoing Challenges and Moving Forward			X	X	X
Statement of Inspector General Michael Missal, Office of Inspector General, Department of Veterans Affairs, Before the U.S. House of Representatives, Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, Hearing on "The Pandemic and VA's Medical Supply Chain: Evaluating the Year-Long Response and Modernization"			X	X	X
Statement of Brent E. Arronte, Deputy Assistant Inspector General, Office of Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs Before the Subcommittee on Disability Assistance and Memorial Affairs Committee on Veterans' Affairs, U.S. House of Representatives Hearing on VA Compensation and Pension Exams During the COVID-19 Pandemic: A Path Forward		X			X

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

The following tables provide a summary of audit-related or management-identified material weaknesses and the noncompliance with FFMIA and Federal financial management system requirements outlined in the 2021 AFR.

Audit Opinion	Unmodified				
Restatement	Yes				
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	1
Obligations, Undelivered Orders and Accrued Expenses	1	-	1	-	-
Financial Systems and Reporting	1	-	-	-	1
IT Security Controls	1	-	-	-	1
Entity Level Controls including CFO Organizational Structure	1	-	1	-	-
Total Material Weaknesses	5	-	2	-	3

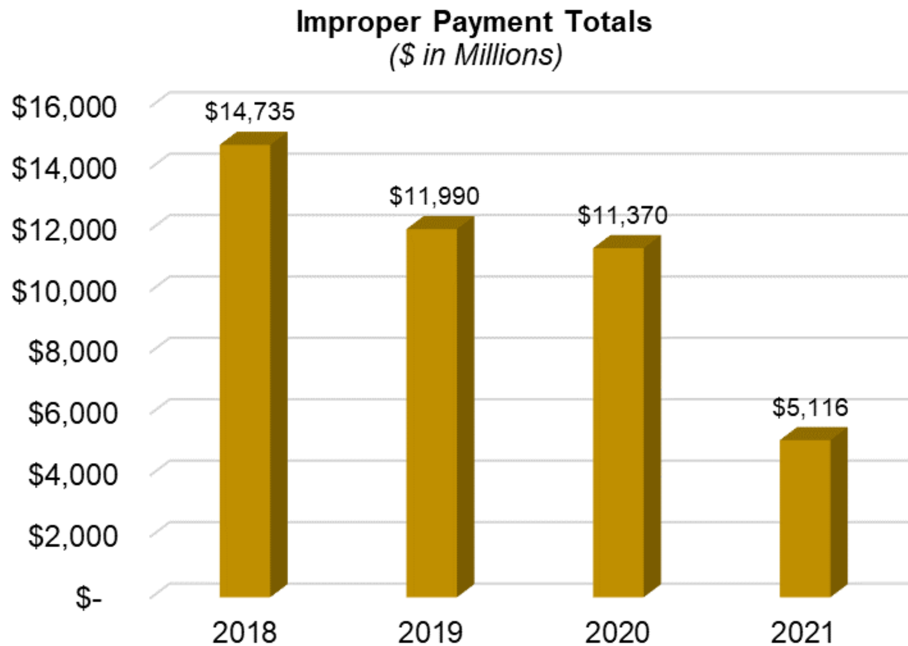
Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)						
Statement of Assurance	Modified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	-	1
Financial Systems and Reporting	1	-	-	-	-	1
Total Material Weaknesses	2	-	-	-	-	2
Effectiveness of Internal Control over Operations (FMFIA § 2)						
Statement of Assurance	Unmodified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Obligations, Undelivered Orders and Accrued Expenses	1	-	1	-	-	-
Entity Level Controls including CFO Organizational Structure	1	-	1	-	-	-
Total Material Weaknesses	2	-	2	-	-	-
Conformance with Federal Financial Management System Requirements (FMFIA § 4)						
Statement of Assurance	Systems conform, except for the below nonconformance					
Nonconformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
IT Security Controls	1	-	-	-	-	1
Total Nonconformances	1	-	-	-	-	1

Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)		
	Agency	Auditor
System Requirements	Lack of compliance noted	Lack of compliance noted
Accounting Standards	No lack of compliance noted	No lack of compliance noted
USSGL at Transaction Level	Lack of compliance noted	Lack of compliance noted

PAYMENT INTEGRITY INFORMATION ACT REPORTING

In FY 2021, VA reports its largest reduction to date of $6.25 billion in improper and unknown payments, a reduction of over 50% from FY2020 results. VA also removed five programs (Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Compensation, Dependency and Indemnity Compensation, Prosthetics and State Home Per Diem Grants) from improper payment reporting, as statistically valid testing showed these programs did not have significant improper payments. Since FY 2018, VA has reduced improper payments by $9.6 billion, a 65% reduction, and removed a total of seven programs from reporting requirements.



VA's Payment Integrity Information Act and high priority program reporting can be found, once published by OMB at https://paymentaccuracy.gov/.

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

The Federal Civil Penalties Inflation Adjustment Act of 1990 (the Inflation Adjustment Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. The table below depicts the covered civil monetary penalties that are under VA's purview.

Statutory Authority	Penalty (Name or Description)	Year Enacted	Latest Year of Adjustment (via Statute or Regulation)	Current Penalty Level ($ Amount or Range)	Sub-Agency/ Bureau/Unit	Location for Penalty Update Details
Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, as amended	False Loan Guaranty Certifications	1986	2021 (via regulation)	The greater of (a) two times the amount of Secretary's loss on the loan, or (b) another appropriate amount not to exceed $23,607	VBA/Loan Guaranty	Federal Register 86 (02/02/2021): 7811-7813
Program Fraud Civil Remedies Act of 1986, as amended	Fraudulent Claims or Statements	1986	2021	$11,803	All VA Programs	Federal Register 86 (02/02/2021): 7811-7813

In February 2021, VA published a regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2021. VA will also publish an updated regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2022. Per the law, VA will update their penalty rates in the Federal Register annually by January 15th.

GRANT PROGRAMS

Pursuant to the OMB Uniform Guidance in 2 C.F.R. § 200.343(b), recipients of grants and cooperative agreements must liquidate all obligations incurred under their awards within 90 days after the end of the period of performance, unless the awarding agency authorizes an extension or program-specific statutes specify a different liquidation period.

VA is required to disclose the number of awards and balances for which closeout has not yet occurred, but for which the period of performance has elapsed by 2 years or more prior to September 30, 2021. The summary of this information is disclosed in the table below.

CATEGORY	2-3 Years	>3-5 Years	>5 Years
Number of Grants/Cooperative Agreements with Zero Dollar Balances	21	21	3
Number of Grants/Cooperative Agreements with Undisbursed Balances	47	14	-
Total Amount of Undisbursed Balances	$6,937,835	$427,219	$ -

Although VA planned to have all grants closed out by September 30, 2021, the Department's response to COVID-19 remained a priority, causing a reduced focus on the closeout of older grants. This shift in priority, in addition to a leadership change, has caused the State Home Construction grant office not to meet the September 30, 2021 goal for closeout. State Home Construction comprises 34 of the grants with undisbursed balances, totaling $6,868,635 .

Additionally, the Adaptive Sports grant office is dealing with staffing shortages and has determined that new grantees need educating on proper procedures to close out awards. Trainings have been planned for grant recipients. Adaptive Sports comprises 27 of the grants with undisbursed balances, totaling $496,419.

TRAILBLAZING WOMEN OF THE VETERANS HEALTH ADMINISTRATION

1867

Mrs. Emma L. Miller was VA's first woman employee, hired as the matron for the Central Branch of the National Home for Disabled Volunteer Soldiers (VHA predecessor) in Dayton, Ohio, in the fall of 1867 and served until her death in 1914.

1890

In 1890, the National Homes' Northwestern Branch in Milwaukee became the first to hire women nurses. After Milwaukee's successful efforts, the remaining National Homes followed suit and by 1898 women nurses worked at all of the National Homes.

1919

In 1919, Lucy Minnigerode, R.N. was appointed as the Public Health Service's first Superintendent of Nursing and oversaw nurses who cared for those afflicted by the 1918–1919 influenza pandemic and returning World War I Veterans.

1924

The first African American women nurses and medical staff were hired in 1924 to work at the Veteran's Bureau hospital for African American World War I veterans in Tuskegee, Alabama.

1946

Dr. Margaret D. Craighill became VA's first chief medical consultant on women Veteran's medical care. Under Dr. Craighill's leadership, VA hired the first 10 female doctors.

1968

Dr. Omega Silva was the first African American woman medical doctor awarded a research associateship at VA in 1968.

1971

Dr. Valerija B. Raulinaitis was the first woman appointed as director of VA hospital at the Leech Farm Road Hospital in Pittsburgh, Pennsylvania in 1971.

Reverend Victoria Hatch was the first woman chaplain at VA. She was appointed as chaplain at the Jerry L. Pettis Memorial VA hospital in Loma Linda, CA.

1977

In 1977, Rosalyn Sussman Yalow became the first VA doctor and second woman ever to receive the Nobel prize for Physiology and Medicine.

1980

Vernice Ferguson was the first African American woman appointed as Director of Nursing Service in 1980.

1984

Viola Johnson became the first African American woman hospital director in Battle Creek Michigan in 1984.

1992

Sue Kinnick planted the seed for what would become VA's Bar Code Medication Administration (BCMA) program in 1992 at the Topeka VAMC.

2000

Dr. Frances M. Murphy became the first woman Deputy Undersecretary for Health in 2000.

2018

Dr. Teresa Boyd became the first woman Chief Medical Officer at VACO in 2018.

2020

Dr. Kameron Matthews became the first African American woman Chief Medical Officer in 2020.