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Washington, DC 20548

Comptroller General
of the United States

April 20, 2020

The Honorable Robert Wilkie
Secretary
U.S. Department of Veterans Affairs
810 Vermont Ave. NW
Washington, D.C. 20420

Priority Open Recommendations: Department of Veterans Affairs

Dear Mr. Secretary:

The purpose of this letter is to provide an update on the overall status of the U.S. Department of Veterans Affairs' (VA) implementation of GAO's recommendations and to call your personal attention to areas where open recommendations should be given high priority.¹ In November 2019, we reported that on a government-wide basis, 77 percent of our recommendations made 4 years before were implemented.² As of April 2020, VA's implementation rate for these recommendations was 88 percent. As of April 2020, VA had 227 open recommendations. Fully implementing all open recommendations could significantly improve VA's operations.

In our March 2019 letter, we highlighted 30 priority recommendations for your department, and since March 2019, VA has implemented 10 of these recommendations. In doing so, VA improved its ability to provide timely access to health care for veterans, ensured that employees who report wrongdoing are treated fairly and are protected against retaliation, and made progress ensuring timely and accurate processing of veterans' enrollment applications, among other things. In addition to the 10 recommendations that VA has implemented, we closed one priority recommendation as unimplemented and removed the priority designation from another recommendation.³

¹Priority recommendations are those that GAO believes warrant priority attention from heads of key departments or agencies. They are highlighted because, upon implementation, they may significantly improve government operation, for example, by realizing large dollar savings; eliminating mismanagement, fraud, and abuse; or making progress toward addressing a [high-risk](#) or [duplication](#) issue.

²GAO, *Performance and Accountability Report: Fiscal Year 2019* [GAO-20-1-1SP](#) (Washington, D.C.: Nov.9, 2019).

³We closed one priority recommendation as unimplemented because the Office of Management and Budget significantly revised its metrics on data center optimization that we had recommended the Department of Veterans Affairs (VA) take action to meet. We replaced this recommendation with a more recent one to take action to meet the revised metrics. (See enclosure.) We removed the priority designation from another recommendation because it became a lower priority after VA provided new information. Specifically, in 2014 we recommended that VA use census tract data to help it make better-informed decisions regarding the location of burial options. In 2019, VA officials provided new information that they make decisions on cemetery locations based in part on the projected, county-level veteran population 30 years in the future. VA officials expressed concern that there would be too much uncertainty trying to perform such long-term population projections at the census tract level. While we removed the priority designation for this recommendation, we continue to maintain the validity of our recommendation and believe that comparing estimates of unserved veterans based on current census tract data with estimates based on current

VA has 18 open priority recommendations remaining from those we identified in the 2019 letter. This year we are adding 15 new recommendations. This brings the total number of priority recommendations to 33. (See enclosure for the list of recommendations.) The 33 priority recommendations fall into the following 10 areas:

Veterans' Access to Timely Health Care. Access to timely primary care medical appointments is critical to ensuring that veterans obtain needed medical care, because primary care is a gateway to obtaining other health care services from the Veterans Health Administration (VHA), including specialty care. Since 2012, we and others have expressed concerns about VHA's difficulties in providing timely access to care and effectively overseeing timely access to health care for veterans, including primary care. We have three priority recommendations to improve VHA's oversight of veterans' access to timely health care. We recommended that VA

- (1) improve the reliability of wait-time measures;
- (2) monitor the full amount of time newly enrolled veterans wait for primary care; and
- (3) establish a comprehensive policy to define Veterans Integrated Service Network (VISN) roles and responsibilities for managing and overseeing medical centers.

Although VA has requested closure of our recommendation to improve the reliability of wait-time measures based on its completed actions, we continue to believe that additional actions are necessary. Specifically, VA's desired date field is subject to interpretation, which poses concerns for the reliability of wait-time measures. Furthermore, VA's first internal audit, in February 2019, was unable to evaluate the accuracy and reliability of its wait-time data due to the lack of business rules for calculating these measures, indicating that additional efforts are needed to address this issue. Among other steps required to fully implement these recommendations, VA needs to provide additional information about its wait-time methodology and assessment of evidence underlying its internal audit findings.

Veterans' Community Care Program. In response to longstanding concerns about the ability of VHA to provide health care services to veterans in a timely manner, the Choice Program was enacted in 2014 to allow veterans to obtain health care services from community-based providers when veterans faced long wait times, lengthy travel distances, or other challenges accessing care at VHA medical facilities.⁴ Over the course of the program, we and others have highlighted weaknesses in VHA's operation and oversight of the Choice Program, such as delays in scheduling appointments. In response to the VA MISSION Act, VA established a new Veterans Community Care Program in 2019.⁵ VA must ensure that veterans receive timely and quality care under this new program.

We have four priority recommendations to improve veterans' community care. We recommended that VA

- (1) monitor female veterans' access to key sex-specific care services—mammography, maternity care, and gynecology—under community care contracts;

county-level data would provide a useful supplement to the VA's use of long-term projected county-level population data.

⁴Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-1765 (2014).

⁵VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, 132 Stat. 1393 (2018).

- (2) establish an achievable wait-time goal that allows it to monitor whether veterans are receiving VA community care within time frames that are comparable to time frames care is received at VA facilities;
- (3) design an appointment scheduling process for community care that establishes time frames for processing, scheduling, and receiving care; and
- (4) establish a system to help facilitate information sharing among VA medical centers, veterans, and others for the purpose of care coordination.

Among other steps required to fully implement these recommendations, VA needs to provide documentation that VHA has established wait-time goals for veterans receiving care in the community. These goals should be comparable to the wait-time goals for VHA facilities. VA agrees with the need to update the community care directives and consult management directives but has not committed to establishing comparable community care wait-time standards.

Human Capital Management. A strong workforce capable of providing quality and timely care to veterans is critical to the success of VA. Over the past two decades, we and others have expressed concern about certain VA human capital practices. For example, in 2017, we reported that VA's employee performance management system was inconsistent with leading human resources practices and that VA did not maintain an accurate count of physicians providing care in the VA system. We also reported in 2018 that VA lacked complete data about employee misconduct and disciplinary actions. Misconduct by VA employees can have serious consequences for veterans, including poor quality of care.

We have four priority recommendations to improve VA's employee performance management, to improve its ability to recruit and retain quality physicians and nurses, and to strengthen its employee misconduct policies. We recommended that VA

- (1) develop a modern and effective performance management system in which VA managers make meaningful distinctions in employees' performance ratings;
- (2) develop a plan to implement a modern IT system to support employee performance management processes;
- (3) develop a process to accurately count all physicians providing care at each VA medical center; and
- (4) collect complete and reliable misconduct and associated disciplinary action data.

Although VA continues to disagree with our recommendation to develop a process to accurately count all physicians providing care at each VA medical center, we continue to believe that creating a system-wide process to collect information on all physicians providing care at VA medical centers, including physicians that are not employed by VA, is essential for accurate workforce planning.

Information Technology. The use of IT is crucial to helping VA effectively serve the nation's veterans, and each year the department spends more than \$4 billion on IT. However, over many years, VA has had difficulty managing its information systems, such as the Veterans Benefits Management System that VA uses to process disability benefits, and has faced challenges consolidating and closing data centers. As a result, we and others have raised questions about the efficiency and effectiveness of VA's IT operations and its ability to deliver intended outcomes needed to help advance the department's mission.

In addition, we have issued several reports on the department's efforts to share the electronic health records of servicemembers and veterans with the Department of Defense (DOD), including the involvement of the DOD and VA Interagency Program Office in these efforts, and VA's plans to acquire a new electronic health record system. Finally, we have reported on VA's efforts to ensure cybersecurity, including issues with identifying critical staffing needs, strengthening online identity verification processes, and establishing risk management programs to address challenges.

We have nine priority recommendations to improve VA's management of its information systems, acquisition of a new electronic health record system, and efforts to ensure cybersecurity. We recommended that VA

- (1) improve its implementation of the Veterans Benefits Management System for processing disability benefits with additional planning and cost estimation;
- (2) clearly define the role and responsibilities of the Interagency Program Office in the governance plans for acquisition of its new electronic health record system;
- (3) take steps to assign appropriate work role codes to positions performing IT, cybersecurity, or cyber-related functions;
- (4) improve its efforts to close data centers;
- (5) take action to meet its data center-related cost savings target;
- (6) improve its efforts to meet data center optimization metrics;
- (7) develop a plan to discontinue knowledge-based verification processes;
- (8) develop a cybersecurity risk management strategy; and
- (9) establish a process for conducting an organization-wide cybersecurity risk assessment.

Among other steps required to fully implement these recommendations, VA needs to estimate the cost to complete the Veterans Benefits Management System, and ensure its cybersecurity risk management strategy includes a statement of risk tolerance and describes how the agency intends to assess, respond to, and monitor cybersecurity risks.

Appeals Reform for Disability Benefits. In recent years the number of appeals of VA's disability benefit decisions has been rising. The Veterans Appeals Improvement and Modernization Act of 2017 required changes to VA's current (legacy) appeals process, giving veterans various options to have their claims reviewed further.⁶ In 2018, we reported that VA's plan for implementing a new disability appeals process did not explain how VA would assess the new process compared to the legacy process, and it did not fully address risks associated with implementing a new process.

We have two priority recommendations to improve VA's disability benefit appeals process. We recommended that VA

- (1) clearly articulate in its appeals plan how it will monitor and assess the new appeals process compared to the legacy process, including specifying a balanced set of goals and measures; and
- (2) ensure that its appeals plan more fully addresses related risks, given the uncertainties associated with implementing a new process.

⁶Pub. L. No. 115-55, 131 Stat. 1105 (2017).

Among the steps required to fully implement these recommendations, VA needs to establish a balanced set of performance goals and measures to assess how well the new appeals process is performing, such as overall timeliness, accuracy, and productivity. VA also needs to assess risks associated with appeals reform against a balanced set of goals. Moreover, many of the principles of sound planning practices that informed our recommendations remain relevant, even after implementation, to ensure the new process meets veterans' needs. VA implemented the new appeals process in February 2019 and continues to agree with these two recommendations.

Quality of Care and Patient Safety. As in all health care delivery settings, VA medical centers are responsible for ensuring that their providers deliver safe, high-quality care to patients. In recent years, we have raised concerns about the quality of care delivered in some VA medical centers. For example, in 2018, we found inconsistent adherence to opioid risk mitigation strategies at selected VA medical centers, such as not conducting urine screenings to determine if veterans are taking their opioid medications as prescribed, and several contributing factors, such as not having a designated primary care pain champion.

We have four priority recommendations to improve the quality and safety of health care delivered in VA medical centers. We recommended that VA

- (1) ensure that all VISNs have implemented a program in which trained clinical pharmacists work with providers to better inform them about evidence-based care (known as academic detailing) and that all VA medical centers have a designated primary care pain champion;
- (2) develop policies and guidance regarding Drug Enforcement Administration (DEA) registrations, including circumstances in which waivers may be required;
- (3) identify and review VA providers whose DEA registrations were revoked or surrendered for cause and determine whether VA needs to obtain DEA waivers to continue employing them; and
- (4) implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure they include documentation that evidence-based treatment options were considered.

Among the steps required to fully implement these recommendations, VA needs to develop policies regarding when a DEA employment waiver may be necessary and guidance about how VA medical centers should request such a waiver.

VA Health Care System Efficiency. VA's strategic plan calls for the efficient use of funds for delivering health care services to veterans. Accordingly, it is critical that VHA closely monitor and account for how its funds are allocated to VA medical centers and redistributed throughout the year to help ensure the most efficient use of funds. In 2019, we found that certain funding allocation adjustments may lead to inefficiencies because medical centers are not required to improve efficiency. For example, we found that some VISNs increased allocations to medical centers with decreasing or relatively flat workloads.

We have one priority recommendation to improve the efficient use of funds for delivering health care services. We recommended that VA revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels.

VHA has stated that it is conducting market assessments over a multi-year period, and after reviewing information resulting from these and other VHA efforts, it may consider adjusting the level of services along with other alternatives. To fully address this recommendation, VHA must demonstrate it has taken these actions or otherwise must revise its guidance to require VISNs—in conjunction with medical centers—to develop approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels.

National Policy Documents. To help carry out its mission of providing timely and high-quality health care to veterans, it is important that VHA develop and communicate national policies throughout the organization and ensure their appropriate implementation. Our work, along with that of the VA Office of Inspector General and others, has cited longstanding concerns about VA's oversight of its health care system, including concerns related to ambiguous policies and inconsistent processes. Specifically, we have found that ambiguous policies have led to inconsistencies in the way VA medical centers operate at the local level, posing risks for veterans' access to health care and for the quality and safety of that care. At the national level, VHA has used a variety of document types to establish policy or to provide implementation guidance to its facilities. In September 2017, we issued a report on VHA's policy management and found that, contrary to its new national policy definitions, VHA continues to issue national policy through program office memos that lack vetting and are not subject to recertification.

We have one priority recommendation to improve the development of national policy. We recommended that VA clarify when and for what purposes each national policy and guidance document type should be used, including whether guidance documents should be vetted and recertified.

Among the steps required to fully implement this recommendation, VHA needs to complete revisions to its national policy directive, which should clarify the use of national policy and guidance documents, as well as their recertification requirements.

Contracting Policies and Practices. Our prior reports have found shortcomings with VA's procurement policy framework and its management of certain procurement programs. For example, in September 2016, we reported that VA's procurement policies were outdated and fragmented, posing challenges for its acquisition workforce. For instance, VA's acquisition regulation had not been updated since 2008. Additionally, in November 2017, we reported that VA did not have a documented overall strategy for its new Medical Surgical Prime Vendor-Next Generation program, which delivers more than \$450 million of supplies to medical centers annually; in January 2019, we reported that VA has not assessed duplication between this program and its Federal Supply Schedule program.

We have three priority recommendations to improve VA's contracting policies and practices. We recommended that VA

- (1) take steps to expedite completion of its updated acquisition regulation;
- (2) document its strategy for its Medical Surgical Prime Vendor-Next Generation program and communicate this plan to all stakeholders; and
- (3) assess duplication between its Medical Surgical Prime Vendor and Federal Supply Schedule programs.

Among the steps to fully implement these recommendations, VA needs to issue the revised acquisition regulation and complete the development and implementation of its process for

prioritizing categories of supplies for requirement development and standardization in future iterations of its Medical Surgical Prime Vendor-Next Generation program.

VA's Capital Planning. VA provides medical services to a veteran population that is growing more diverse. These demographic shifts will drive changes in veterans' needs and expectations, and require adjustments to VA medical facilities. In June 2019, we reported that VA did not clearly instruct VA medical centers on how to meet the agency's strategic goal of incorporating veterans' changing needs and expectations into facility planning. We also found that although VA had established a process to help facilities estimate space needs, officials at the facilities questioned its accuracy.

We have two priority recommendations to improve VA's capital planning. We recommend that VA

- (1) instruct its medical centers on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources and tools and directing medical centers to use them; and
- (2) systematically gather feedback from facility planners and address any concerns about the reliability of VA's process for estimating space needs.

Among the steps required to fully implement these recommendations, VA needs to provide guidance to its medical centers, provide updated training to facility planners, and gather feedback on VA's process for estimating space needs.

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We recognize that many officials within the components of VA responsible for addressing these priority recommendations are currently focused on the nation's efforts to respond to and recover from the Coronavirus Disease 2019 (COVID-19) pandemic. As VA is able to refocus its efforts, we believe implementing our VA priority recommendations could be done in conjunction with efforts to address [high-risk areas](#) related to VA. As you know, in March 2019, we issued our biennial update to our high-risk program, which identifies government operations with greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.⁷ Our high-risk program has served to identify and help resolve serious weaknesses in areas that involve substantial resources and provide critical service to the public. In addition, as we recently reported, we plan to designate national efforts to prevent, respond to, and recover from drug misuse as a high-risk area in our 2021 High Risk Update.

Two of our high-risk areas—[managing risks and improving VA health care](#) and [VA acquisition management](#)—center directly on VA. Several other government-wide high-risk areas also have direct implications for VA and its operations, including (1) [improving and modernizing federal disability programs](#), (2) [improving the management of IT acquisitions and operations](#), (3) [strategic human capital management](#), (4) [managing federal real property](#), and (5) [government-wide personnel security clearance process](#). We also want to call your attention to one additional government-wide high-risk area that has direct implications for VA and its operations: [ensuring](#)

⁷GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

[the cybersecurity of the nation](#).⁸ In particular, we encourage you to give attention to our recommendations related to strengthening the access controls and security configurations of VA's high-impact systems, and to comprehensively test the controls of those systems. Continued vigilance in this area is needed. We urge your attention to the two VA high-risk areas and to the other government-wide high-risk areas as they relate to VA. Progress on high-risk issues has been possible through the concerted actions and efforts of Congress, the Office of Management and Budget (OMB), and the leadership and staff in agencies, including VA.

Copies of this report are being sent to the Director of OMB and appropriate congressional committees including the Committees on Appropriations, Budget, and Homeland Security and Governmental Affairs, United States Senate; and the Committees on Appropriations, Budget, and Oversight and Reform, House of Representatives. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

I appreciate VA's continued commitment to these important issues. If you have any questions or would like to discuss any of the issues outlined in this letter, please do not hesitate to contact me or A. Nicole Clowers, Managing Director, Health Care at clowersa@gao.gov or 202-512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Our teams will continue to coordinate with your staff on all of the 227 open recommendations. Thank you for your attention to these matters.

Sincerely yours,



Gene L. Dodaro
Comptroller General
of the United States

Enclosure - 1

cc: Dr. Paul R. Lawrence, Under Secretary for Benefits, VA
Dr. Richard A. Stone, Executive in Charge, VHA
Mr. Daniel R. Sitterly, Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness, VA
Mr. James P. Gfrerer, Assistant Secretary for Information and Technology and Chief Information Officer, VA
Ms. Karen Brazell, Principal Executive Director and Chief Acquisition Officer, Office of Acquisition, Logistics and Construction, VA
Mr. Nathan D. Turnipseed, Acting Director, VHA Medical Supply Program, VHA Procurement and Logistics Office, VHA
Mr. Michael J. Missal, Inspector General, VA

⁸[GAO-19-157SP](#). See pages 275 to 282 for Managing Risks and Improving VA Health Care; pages 210 to 216 for VA Acquisition Management; pages 259 to 266 for Improving and Modernizing Federal Disability Programs; pages 123 to 127 for Improving the Management of IT Acquisitions and Operations; pages 75 to 77 for Strategic Human Capital Management; pages 78 to 85 for Managing Federal Real Property; pages 170 to 177 for Government-wide Personnel Security Clearance Process; and pages 178 to 184 for Ensuring the Cybersecurity of the Nation.

Enclosure

Priority Open Recommendations to VA

Improving Oversight of Veterans' Access to Timely Health Care

VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement. [GAO-13-130](#). Washington, D.C.: December 21, 2012.

Recommendation: To ensure reliable measurement of veterans' wait times for medical appointments, we recommend that the Secretary of the Department of Veterans Affairs (VA) direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error.

Action Needed: VA agreed with our recommendation. VA has taken actions intended to address the reliability of appointment wait times through improvements in appointment scheduling, including issuing a revised scheduling policy, providing and documenting scheduler training, and improving oversight through scheduler audits. While the revised scheduling policy and subsequent guidance changed the terminology of wait-time measures, they did not substantively clarify or define the desired date. Therefore, we continue to believe that the desired date field is still subject to interpretation and prone to scheduler error, which poses concerns for the reliability of wait times measured using patients' desired dates. Furthermore, VA's first internal audit in February 2019 was unable to evaluate the accuracy and reliability of its wait-time data due to the lack of business rules for calculating them, indicating that additional efforts are needed to address this issue. Given our continued concerns about VA's ability to ensure the reliability of the wait-time data, we have requested additional information from VA about its wait-time methodology and assessment of evidence underlying the audit findings.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Debra A. Draper, Health Care

Contact information: draperd@gao.gov, (202) 512-7114

VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care. [GAO-16-328](#). Washington, D.C.: March 18, 2016.

Recommendation: The Secretary of VA should direct the Under Secretary for Health to monitor the full amount of time newly enrolled veterans wait to be seen by primary care providers, starting with the date veterans request they be contacted to schedule appointments. This could be accomplished, for example, by building on the data collection efforts currently being implemented under the "Welcome to VA" program.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to provide documentation that it captures the application date for all newly enrolled veterans.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Debra A. Draper, Health Care

Contact information: draperd@gao.gov, (202) 512-7114

Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities. [GAO-19-462](#). Washington, D.C.: June 19, 2019.

Recommendation: The Under Secretary for Health should establish a comprehensive policy that clearly defines Veterans Integrated Service Network (VISN) roles and responsibilities for managing and overseeing medical centers.

Action Needed: VA agreed in principle with our recommendation. To fully implement this recommendation, the Veterans Health Administration (VHA) will need to develop a policy—which VHA requires to assign responsibilities for executing a course of action to individuals or groups—that defines VISN roles and responsibilities for managing and overseeing medical centers.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Debra A. Draper, Health Care

Contact information: draperd@gao.gov, (202) 512-7114

Improving Oversight of Veterans' Community Care Program

VA Health Care: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans. [GAO-17-52](#). Washington, D.C.: December 2, 2016.

Recommendation: To improve care for women veterans, we recommend that the Secretary of VA direct the Under Secretary for Health to monitor women veterans' access to key sex-specific care services—mammography, maternity care, and gynecology—under current and future community care contracts. For those key services, monitoring should include an examination of appointment scheduling and completion times, driving times to appointments, and reasons appointments could not be scheduled with community providers.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VHA needs to provide documentation that, as a part of all future community care programs, there is a plan (with time frames, data analyzed, and actions taken) relating to the monitoring of women's health services (specifically, gynecology, maternity care, and mammography) for timely appointment scheduling, timely completion times, driving times to appointments, and reasons appointments could not be scheduled with community providers.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs. [GAO-18-281](#). Washington, D.C.: June 4, 2018.

Recommendation: The Under Secretary for Health should establish an achievable wait-time goal for the consolidated community care program that VA plans to implement that will permit VHA to monitor whether veterans are receiving VA community care within time frames that are comparable to the amount of time they would otherwise wait to receive care at VHA medical facilities.

Recommendation: The Under Secretary for Health should design an appointment scheduling process for the consolidated community care program that VA plans to implement that sets forth time frames within which (1) veterans' referrals must be processed, (2) veterans' appointments must be scheduled, and (3) veterans' appointments must occur, which are consistent with the wait-time goal VHA has established for the program.

Recommendation: The Secretary of VA should establish a system for the consolidated community care program VA plans to implement to help facilitate seamless, efficient information sharing among VA medical centers (VAMC), VHA clinicians, third party administrators (TPA), community providers, and veterans. Specifically, this system should allow all of these entities to electronically exchange information for the purposes of care coordination.

Action Needed: VA agreed with our recommendations. To fully implement these recommendations, VHA will need to take the following actions: (1) establish community care program wait-time goals; (2) design an appointment scheduling process for community care that is in keeping with these established wait-time goals that outlines time frames for completion of the various steps in the appointment scheduling process, such as when referrals must be processed, appointments scheduled, and veterans seen by the provider; (3) measure the timeliness of veterans seen in VHA medical facilities and by community care providers; (4) determine if veterans are receiving VA community care within time frames that are comparable to the amount of time they would wait to receive care at VHA medical facilities; and (5) develop a tool that would facilitate the electronic exchange of administrative and clinical information between VHA, the TPAs, and community providers.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Improving Management of Human Capital

Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges. [GAO-17-30](#). Washington, D.C.: December 23, 2016.

Recommendation: To accelerate efforts to develop a modern, credible, and effective performance management system, the Assistant Secretary for Human Resources and Administration (HR&A), with input from VHA stakeholders, should ensure that meaningful distinctions are being made in employee performance ratings by (1) developing and

implementing a standardized, comprehensive performance management training program for supervisors of Title 5, Title 38, and Title 38-Hybrid employees based on leading practices, and ensuring procedures are in place to support effective performance conversations between supervisors and employees; (2) reviewing and revising Title 5 and Title 38 performance management policies consistent with leading practices (e.g., require definition of all performance levels); and (3) developing and implementing a process to standardize performance plan elements, standards, and metrics for common positions across VHA that are covered under VA's Title 5 performance management system.

Recommendation: To accelerate efforts to develop a modern, credible, and effective performance management system, the Assistant Secretary for HR&A should, with input from VHA stakeholders, develop a plan for how and when it intends to implement a modern information technology (IT) system to support employee performance management processes.

Action Needed: VA partially agreed with our recommendations. VA has taken important steps towards addressing these recommendations. However, to fully implement the recommendations, VA needs to complete additional planned steps. Specifically, in January 2020, VA officials said they were piloting a new performance management system, with plans to develop an enterprise-wide performance management solution. Activities such as finalizing a business case and analyzing alternatives are still in progress. Officials also stated that performance management policy revisions are scheduled to be completed later in 2020.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Michelle Rosenberg, Strategic Issues

Contact information: rosenbergm@gao.gov, (202) 512-6806

Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. [GAO-18-124](#). Washington, D.C.: October 19, 2017.

Recommendation: The Under Secretary for Health should develop and implement a process to accurately count all physicians providing care at each medical center, including physicians who are not employed by VHA.

Action Needed: As of January 2020, VA continues to disagree with the recommendation. Although VA responded to our report by stating that the ability to count physicians does not affect its ability to assess workload, we continue to believe that VHA needs a systematic process that is available at the local level to identify all physicians working at VA medical centers as part of the agency's efforts to monitor and assess workload. To implement the recommendation, VHA needs to develop a system-wide process to collect workload information on all physicians providing care at VAMCs, including physicians that are not employed by VHA. This information should be available at the local level for workforce planning purposes.

High Risk Area: [Managing Risks and Improving VA Health Care](#), [Strategic Human Capital Management](#)

Director: Debra A. Draper, Health Care

Contact information: draperd@gao.gov, (202) 512-7114

Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability. [GAO-18-137](#). Washington, D.C.: July 19, 2018.

Recommendation: The Secretary of VA should develop and implement guidance to collect complete and reliable misconduct and associated disciplinary-action data department-wide, whether through a single information system, or multiple interoperable systems. Such guidance should include direction and procedures on addressing blank data fields, lack of personnel identifiers, and standardization among fields, and on accessibility.

Action Needed: VA agreed with our recommendation. In March 2020, VA provided documentation that they have developed and implemented a Software-as-a-Service Solution, Automated Labor and Employee Relations Tracker (ALERT-HR). Additional follow-up is needed to determine whether this software collects complete and reliable misconduct and associated disciplinary action data department-wide. To fully implement this recommendation, VA must provide evidence of its new policy and information system. The policy must include procedures on addressing the lack of personnel identifiers, blank data fields, standardization among data fields, and accessibility.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Kathy Larin, Forensic Audits and Investigative Service

Contact information: larink@gao.gov, (202) 512-5045

Improving Management of Information Technology

Veterans Benefits Management System: Ongoing Development and Implementation Can Be Improved; Goals Are Needed to Promote Increased User Satisfaction. [GAO-15-582](#). Washington, D.C.: September 1, 2015.

Recommendation: To improve VA's efforts to effectively complete the development and implementation of the Veterans Benefits Management System (VBMS), the Secretary of VA should direct the Under Secretary for Benefits and the Chief Information Officer to develop an updated plan for VBMS that includes (1) a schedule for when the Veterans Benefits Administration intends to complete development and implementation of the system, including capabilities that fully support disability claims, pension claims, and appeals processing; and (2) the estimated cost to complete development and implementation of the system.

Action Needed: VA agreed with our recommendation and is continuing to develop requirements for VBMS in order to increase the system's functionality and to allow for the replacement of legacy information systems. In addition, the department provided us with expected completion dates for implementation of capabilities that support claims and appeals processing, but has not provided a schedule for the implementation of pension claims processing. To fully implement this recommendation, the department needs to provide the expected completion date for pension claims processing and an estimated cost to complete remaining development and implementation of VBMS.

High Risk Area: [Improving the Management of IT Acquisitions and Operations](#)

Director: Carol C. Harris, Information Technology and Cybersecurity

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Electronic Health Records: Clear Definition of the Interagency Program Office's Role in VA's New Modernization Effort Would Strengthen Accountability. [GAO-18-696T](#). Washington, D.C.: September 13, 2018.

Recommendation: The Secretary of VA should ensure that the role and responsibilities of the Interagency Program Office are clearly defined within the governance plans for acquisition of the department's new electronic health record system.

Action Needed: VA agreed with our recommendation and, working in conjunction with the Department of Defense, had re-chartered the Interagency Program Office as the Federal Electronic Health Record Modernization (FEHRM) program office. The FEHRM is the joint VA and DOD governance body and serves as the single point of accountability in the delivery of a common health record between the two departments. However, the corresponding Implementation Plan that is intended to document how the FEHRM program office executes its governance responsibilities has yet to be issued. To fully implement this recommendation, VA needs to document the role and responsibilities of the FEHRM program office with respect to VA's acquisition of its new electronic health record system, explaining the role, if any, the FEHRM program office will have in the governance process.

High Risk Area: [Improving the Management of IT Acquisitions and Operations](#)

Director: Carol C. Harris, Information Technology and Cybersecurity

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Cybersecurity Workforce: Agencies Need to Accurately Categorize Positions to Effectively Identify Critical Staffing Needs. [GAO-19-144](#). Washington, D.C.: March 12, 2019.

Recommendation: To complete the appropriate assignment of codes to their positions performing IT, cybersecurity, or cyber-related functions, in accordance with the requirements of the Federal Cybersecurity Workforce Assessment Act of 2015, the Secretary of Veterans Affairs should take steps to review the assignment of the "000" code to any positions in the department in the 2210 IT management occupational series and assign the appropriate National Initiative for Cybersecurity Education (NICE) work role codes.

Action Needed: VA agreed with our recommendation and has reviewed its positions in the 2210 IT management occupational series and assigned appropriate work role codes in the Office of Information and Technology's Personnel Management System. Officials stated that the updated codes would be applied in the department's human resources system of record by March 31, 2020. To fully implement this recommendation, VA will need to provide evidence showing that it has recorded appropriate work role codes for positions performing IT, cybersecurity, or cyber-related functions in its human resources system of record.

High Risk Area: [Ensuring the Cybersecurity of the Nation](#)

Director: Carol C. Harris, Information Technology and Cybersecurity

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Data Center Optimization: Additional Agency Actions Needed to Meet OMB Goals. [GAO-19-241](#). Washington, D.C.: April 11, 2019.

Recommendation: The Secretary of VA should take action to meet the data center closure targets established under Data Center Optimization Initiative (DCOI) by the Office of Management and Budget (OMB).

Action Needed: VA agreed with our recommendation and reported important steps toward implementing this recommendation in its fiscal year 2021 budget justification. As of January 2020, the department reported that it had closed 16 data centers to meet its fiscal year 2019 closure target. However, we continue to believe that full implementation of this recommendation will require steps beyond what the department is currently reporting. Specifically, VA will need to demonstrate sustained implementation progress over time, including meeting its fiscal year 2020 data center closure target.

Recommendation: The Secretary of VA should take action to meet the data center-related cost savings established under DCOI by OMB.

Action Needed: VA agreed with our recommendation and reported important steps toward implementing this recommendation in its fiscal year 2021 justification. As of January 2020, the department reported that it had met its fiscal year 2019 cost savings target. However, we continue to believe that full implementation of this recommendation will require steps beyond what the department is currently reporting. Specifically, VA will need to demonstrate sustained implementation progress over time, including meeting its fiscal year 2020 data center cost-savings target.

Recommendation: The Secretary of VA should take action to meet the data center optimization metric targets established under DCOI by OMB.

Action Needed: VA agreed with our recommendation and reported important steps toward implementing this recommendation in its fiscal year 2021 budget justification. As of January 2020, the department reported that it had met its fiscal year 2019 targets for three of the four data center optimization metrics tracked by OMB. However, we continue to believe that full implementation of this recommendation will require steps beyond what the department is currently reporting. Specifically, to fully implement this recommendation, VA will need to meet all four of OMB's metrics, and also demonstrate sustained implementation progress over time by continuing to meet the four metrics across fiscal years.

High Risk Area: [Improving the Management of IT Acquisitions and Operations](#)

Director: Carol C. Harris, Information Technology and Cybersecurity

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Data Protection: Federal Agencies Need to Strengthen Online Identity Verification Processes. [GAO-19-288](#). Washington, D.C.: May 17, 2019.

Recommendation: The Secretary of the Department of Veterans Affairs should develop a plan with time frames and milestones to discontinue knowledge-based verification, such as by using Login.gov or other alternative verification techniques.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to develop a plan with milestones to document the results of their evaluation of the alternatives the department stated it is interested in pursuing.

High Risk Area: [Ensuring the Cybersecurity of the Nation](#)

Director: Nick Marinos, Information Technology and Cybersecurity

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Cybersecurity: Agencies Need to Fully Establish Risk Management Programs and Address Challenges. [GAO-19-384](#). Washington, D.C.: July 25, 2019.

Recommendation: The Secretary of VA should develop a cybersecurity risk management strategy that includes the key elements identified in this report.

Action Needed: VA agreed with our recommendation. We worked with responsible agency officials in March 2020 to reconcile the status it reported in its fiscal year 2021 budget justification with the findings from our recommendation follow-up. We reached agreement on the status as follows: VA has indicated that it is working to develop a cybersecurity risk-management strategy as part of a comprehensive risk management program plan, which the department intends to finalize by June 30, 2020. To fully implement this recommendation, VA will need to ensure that its strategy addresses key elements identified in our report, including a statement of risk tolerance and how the agency intends to assess, respond to, and monitor cybersecurity risks.

Recommendation: The Secretary of VA should establish a process for conducting an organization-wide cybersecurity risk assessment.

Action Needed: VA agreed with our recommendation and indicated that it is working to establish a process for an organization-wide cybersecurity risk assessment as part of a comprehensive risk-management program plan, which the department intends to finalize by June 30, 2020. To fully implement this recommendation, VA will need to ensure that it has established a process for aggregating and assessing cyber-related risks from across its organization.

High Risk Area: [Ensuring the Cybersecurity of the Nation](#)

Director: Nick Marinos, Information Technology and Cybersecurity

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Improving Appeals Reform for Disability Benefits

VA Disability Benefits: Improved Planning Practices Would Better Ensure Successful Appeals Reform. [GAO-18-352](#). Washington, D.C.: March 22, 2018.

Recommendation: The Secretary of VA should clearly articulate in VA's appeals plan how VA will monitor and assess the new appeals process compared to the legacy process, including specifying a balanced set of goals and measures—such as timeliness goals for all the Veterans Benefits Administration (VBA) appeals options and the Board of Veterans' Appeals (Board) dockets, and measures of accuracy, veteran satisfaction, and cost—and related baseline data.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to establish a balanced set of performance goals for all new appeals options and a balanced set of measures, including overall timeliness, accuracy, and productivity, as well as a system to assess how well the new process is performing relative to the legacy process.

Recommendation: The Secretary of VA should ensure that the appeals plan more fully addresses risk associated with appeals reform—for example, by assessing risks against a balanced set of goals and measures, articulating success criteria and an assessment plan for the Rapid Appeals Modernization Program (RAMP), and testing or conducting sensitivity analyses of all appeal options—prior to fully implementing the new appeals process.

Action Needed: VA agreed with our recommendation and took several steps to identify risks prior to fully implementing its new disability appeals process. Moreover, many of the principles of sound planning practices that informed our recommendation remain relevant, even after implementation. VA needs to continue applying these principles to better address risks associated with implementing the new process. To fully implement our recommendation, VA will need to develop and document plans to fully address risks, including assessing risks against a balanced set of goals for all new appeals options to ensure the new process meets veterans' needs. Further, VA needs to develop and document risk mitigation strategies that address veterans appealing to the Board at higher rates than expected and choosing the more resource-intensive options involving new evidence or hearings, which potentially subject veterans to longer wait times.

High Risk Area: [Improving and Modernizing Federal Disability Programs](#)

Director: Elizabeth Curda, Education, Workforce, and Income Security

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Ensuring Safe, High-Quality Care for Veterans

VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed. [GAO-18-380](#). Washington, D.C.: May 29, 2018.

Recommendation: The Under Secretary for Health should ensure that all VISNs have implemented an academic detailing program that supports all medical facilities in the VISN and that all VHA medical facilities have a designated primary care pain champion as required.

Action Needed: VA agreed with our recommendation and in November 2019, reported taking actions toward addressing it. VISN officials from all 18 VISNs attested to the Under Secretary for Health that each facility had designated a primary care pain champion and had implemented an academic detailing program. To fully implement this recommendation, VHA needs to ensure, that its academic detailing programs regularly provide education and support to all VHA medical facilities.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Managing Director: A. Nicole Clowers, Health Care

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Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care. [GAO-19-6](#). Washington, D.C.: February 28, 2019.

Recommendation: The Under Secretary for Health should develop policies and guidance regarding Drug Enforcement Administration (DEA) registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies.

Action Needed: VA agreed with our recommendation. We worked with responsible agency officials in March 2020 to reconcile the status it reported in its fiscal year 2021 budget justification with the findings from our recommendation follow-up. We reached agreement on the status as follows: VA sent a letter to DEA asking for clarification about DEA employment waivers and received a response from DEA dated November 26, 2019. VA officials told us that they are considering the input from DEA and consulting with relevant stakeholders to determine next steps. To fully implement this recommendation, VA needs to provide evidence of actions taken to ensure that DEA requirements regarding DEA registrations and employment waivers are met. Such actions include developing policies regarding when a DEA employment waiver may be necessary and guidance about how to request such a waiver.

Recommendation: The Under Secretary for Health should identify and review providers whose DEA registrations were revoked or surrendered for cause and determine whether an employment waiver may be needed from DEA.

Action Needed: VA agreed with our recommendation. VA officials told us that they reviewed licensed independent practitioners to see if any that are currently employed at VA have a revoked or surrendered DEA registration. They identified at least one provider with a revoked or surrendered DEA registration. To fully implement this recommendation, VA needs to provide evidence that appropriate action was taken for this provider, such as obtaining a DEA waiver if necessary.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Kathy Larin, Forensic Audits and Investigative Service

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VA Mental Health: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight. [GAO-19-465](#): Washington, D.C.: June 17, 2019.

Recommendation: The Veterans Health Administration should develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered.

Action Needed: VA agreed with this recommendation. To fully implement this recommendation, VHA needs to provide us with a copy of a May 2019 memo that reportedly required all VAMCs to implement quality review processes to ensure each licensed independent provider had five mental health treatment plans reviewed biannually. We would expect to see that VHA requires the review processes to verify the treatment plans included documentation of (1) the treatment being provided, (2) consideration of different evidence-based options, and (3) evaluation of care on an ongoing basis and evidence of modifications to treatment plans, if needed. Additionally, VHA needs to provide us with supporting documentation indicating that all VAMCs have attested to implementing the quality review processes and describing how VAMCs are to report the results of their biannual reviews to VHA.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Debra A. Draper, Health Care

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Ensuring Efficiency within the VA Health Care System

Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding. [GAO-19-670](#). Washington, D.C.: September 23, 2019.

Recommendation: The VA Under Secretary of Health should revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered.

Action Needed: VA agreed in principle with our recommendation. VHA stated that it is conducting market assessments over a multi-year period to increase access and quality of care to veterans. VHA said that after completing the market assessments and reviewing information from other VHA efforts, it may consider adjusting the level of services along with other alternatives. VHA reported that it plans to address this recommendation by December 2020. To fully implement this recommendation, VHA needs to demonstrate it has taken these actions or otherwise must revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

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Improving Management of National Policy Documents

Veterans Health Care: Additional Actions Could Further Improve Policy Management. [GAO-17-748](#). Washington, D.C.: September 22, 2017.

Recommendation: The Under Secretary for Health should further clarify when and for what purposes each national policy and guidance document type should be used, including whether guidance documents, such as program office memos, should be vetted and recertified.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VHA needs to provide us with the finalized version of its national policy directive. The directive should include VHA's clarification on the use of national policy and guidance documents, as described in a November 2019 interim policy. The directive should also include VHA's vetting and recertification requirements for operational memos that VHA established in October 2019 through a separate interim policy. Because VHA interim policy, by definition, is automatically rescinded after 1 year unless incorporated into a directive, VHA needs to provide us with the finalized version of its recertified national policy directive.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Debra A. Draper, Health Care

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Improving Management of Contracting Policies and Practices

Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency. [GAO-16-810](#). Washington, D.C.: September 16, 2016.

Recommendation: In order to ensure that contracting officers have clear and effective policies as soon as possible, the Secretary of VA should direct the Office of Acquisition and Logistics to identify measures to expedite the revision of the Veterans Affairs Acquisition Regulation, which has been ongoing for many years, and the issuance of the VA Acquisition Manual.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to expedite the issuance of its revised VA Acquisition Regulation, as well as the companion VA Acquisition Manual to ensure its workforce has clear and effective policies. As of January 2020, VA issued 25 proposed or final rules with the remaining 16 expected to be published as draft rules by April 2021.

High Risk Area: [VA Acquisition Management](#)

Director: Shelby Oakley, Contracting and National Security Acquisitions

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Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency. [GAO-18-34](#). Washington, D.C.: November 9, 2017.

Recommendation: The Director of the Medical Surgical Prime Vendor-Next Generation program office should, with input from the Strategic Acquisition Center, develop, document, and communicate to stakeholders an overarching strategy for the program, including how the program office will prioritize categories of supplies for future phases of requirement development and contracting.

Action Needed: VA agreed with our recommendation. VA planned to implement a new Medical Surgical Prime Vendor (MSPV) program, called MSPV 2.0, by March 2020. However, VA stated that this program is delayed until at least October 2020. VA further stated that its MSPV 2.0 program strategy will include involving clinicians in requirement development of medical supply purchases. While VA is currently engaging selected clinicians in its requirement development for a set list of products, VA does not plan to resume focus on standardization until after MSPV 2.0 begins.

High Risk Area: [VA Acquisition Management](#)

Director: Shelby Oakley, Contracting and National Security Acquisitions

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VA Acquisition Management: Steps Needed to Ensure Healthcare Federal Supply Schedules Remain Useful. [GAO-20-132](#). Washington, D.C.: January 9, 2020.

Recommendation: The Secretary of Veterans Affairs should take steps to assess duplication between VA's Federal Supply Schedules (FSS) and MSPV programs, to determine if this duplication is necessary or if efficiencies can be gained.

Action Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to complete its assessment of whether duplication across its VA FSS and MSPV programs is necessary and efficient. VA expects to complete an internal report that will address this issue in June 2020.

High Risk Area: [VA Acquisition Management](#)

Director: Shelby Oakley, Contracting and National Security Acquisitions

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Improving VA's Capital Planning

VA Real Property: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations. [GAO-19-440](#). Washington, D.C.: June 13, 2019.

Recommendation: To improve VA's ability to plan for and align its facilities with estimated changes to veterans' needs and expectations, we recommend that the Secretary of Veterans Affairs ensure the appropriate offices and administrations instruct VAMCs on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources or tools and directing VAMCs to use them.

Action Needed: VA agreed with the recommendation and indicated that it would instruct users on what data to use in planning and updates, which would help ensure veterans' input is incorporated where appropriate. To fully implement this recommendation, VA needs to provide this guidance to the VAMCs, which the agency expects to do in scheduled facility planning calls estimated to start in the second quarter of fiscal year 2020.

Recommendation: To improve VA's ability to plan for and align its facilities with estimated changes to veterans' needs and expectations, we recommend that the Secretary of Veterans Affairs ensure the appropriate offices and administrations systematically gather feedback from facility planners and address (as necessary) their concerns with the reliability of the Strategic Capital Investment Planning (SCIP) process, including providing additional information on how SCIP's space estimates are derived.

Action Needed: VA agreed with this recommendation. To fully implement this recommendation, VA needs to complete its efforts to update its training instructions to facility planners by adding an explanation of how SCIP space estimates are derived. In addition, VA needs to complete its planned survey of facility planners about their concerns with the SCIP space estimates, and use these results to either address the concerns or make improvements to SCIP.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

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