VA ADMINISTRATIVE INVESTIGATIONS

Improvements Needed in Collecting and Sharing Information

Why GAO Did This Study

VA may use an AIB to determine the facts surrounding alleged employee misconduct or potential systemic deficiencies related to VA policies or procedures. AIBs do not determine corrective actions, such as individual disciplinary actions or procedural changes, but AIB investigation results, including evidence, may be used to inform such actions, making it critical for AIBs to be convened and conducted appropriately.

You expressed interest in the number of AIB investigations and their results. In this report, GAO examines (1) the process VA uses to convene and conduct AIB investigations, (2) the extent to which VA collects data on AIB investigations, and (3) how VA has used the results of its AIB investigations. GAO focused on AIB investigations conducted within VHA; reviewed VA documents, including policies and procedures, and VHA data on AIBs conducted during fiscal years 2009 through 2011; and interviewed VA officials from headquarters and four medical centers. To ensure data reliability, GAO reviewed VHA’s methods to collect AIB data.

What GAO Found

The Department of Veterans Affairs (VA) has departmentwide policy and procedures for convening and conducting administrative investigation boards (AIB). The department’s procedures contain requirements for convening and conducting AIB investigations, but according to VA officials, they also provide the flexibility to tailor an investigation to effectively meet diverse informational needs. For example, the VA official convening an AIB investigation is required to select AIB members who are impartial and objective, but has flexibility to vary the number of members appointed to each AIB based on the matter being investigated. VA is currently updating its AIB policy and procedures, but officials said the department plans to maintain flexibility in its AIB process.

VA does not collect and analyze aggregate data on AIB investigations, including data on the number of AIB investigations conducted, the types of matters investigated, and whether the matters were substantiated, or on any systemic deficiencies identified by AIBs. Having aggregate data could provide VA with valuable information to systematically gauge the extent to which matters investigated by AIBs may be occurring throughout VA’s Veterans Health Administration (VHA) and to take corrective action, if needed, to reduce the likelihood of future occurrences. Without such data, VA is unable to adequately assess the causes or factors that may contribute to deficiencies occurring within its medical centers and health care networks. Information on AIB investigations is maintained by different offices across VA. For example, each medical center or network maintains information on each AIB investigation that it conducts. In response to GAO’s request for AIB data, VHA administered a web-based survey that collected data from all its medical centers and networks on AIB investigations they reported conducting during fiscal years 2009 through 2011. Survey data showed that medical centers and networks conducted more than 1,100 investigations during this time period, and the types of matters investigated included allegations of inappropriate employee behavior involving patients and other employees; individual employee wrongdoing, such as theft and fraud; and systemic deficiencies. VHA officials told us that although it administered the web-based survey, the department has no plans to collect and analyze aggregate data on AIB investigations conducted within VHA.

VA has used the results of AIB investigations to inform corrective actions, but does not share information about improvements made that could have broader applicability. Specifically, VA has used the results of AIB investigations to inform systemic changes at the medical centers and networks where AIB investigations have been conducted. For example, VA has developed new policies and procedures for improving patient and employee safety and developed new training programs to expand employees’ knowledge of VA policies and procedures. However, VA does not share information about these improvements that may have relevance for other areas within VHA. Such information could be used to improve not only the quality of patient care provided, but also the efficiency of VHA’s overall operations. For example, one medical center included in GAO’s review implemented a tracking system to ensure surgical instruments are delivered promptly to the operating room and a checklist to ensure the availability of needed equipment prior to starting surgery.

What GAO Recommends

GAO recommends that VA establish processes to (1) collect and analyze aggregate data from AIB investigations conducted within VHA, and (2) share information about improvements that are implemented in response to the results of AIB investigations. VA concurred with these recommendations.