United States Government Accountability Office

Report to Congressional Requesters

July 2023

VA HEALTH CARE

Office of the Medical Inspector Should Strengthen Oversight of Recommendations and Assess Performance

GAO-23-105634

GAO Highlights

Highlights of GAO-23-105634, a report to congressional requesters

Why GAO Did This Study

VHA operates one of the largest health care systems in the nation, serving about 9 million veterans annually. The Office of the Medical Inspector is one of several oversight offices within VHA and is responsible for investigating quality-of-care concerns at VHA health care facilities.

GAO was asked to review the Office of the Medical Inspector. Among other objectives, this report examines the office's (1) caseload and staffing levels, (2) process for determining whether recommendations have been implemented, and (3) efforts to assess its performance.

GAO examined the Office of the Medical Inspector's documentation, such as policies, and information about its cases, staffing levels, and recommendations from fiscal years 2017 through 2022 (the most recent information available at the time). GAO also interviewed officials from the Office of the Medical Inspector and other relevant VA offices.

What GAO Recommends

GAO is recommending that the Office of the Medical Inspector (1) establish supervisory review for assessing recommendation implementation, (2) establish strategic goals and related performance goals, (3) establish performance measures and collect relevant information to measure progress toward goals, and (4) regularly use such information to assess progress toward goals and inform management decisions. VA concurred with the recommendations and identified steps to implement them.

View GAO-23-105634. For more information, contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov.

July 2023

VA HEALTH CARE

Office of the Medical Inspector Should Strengthen Oversight of Recommendations and Assess Performance

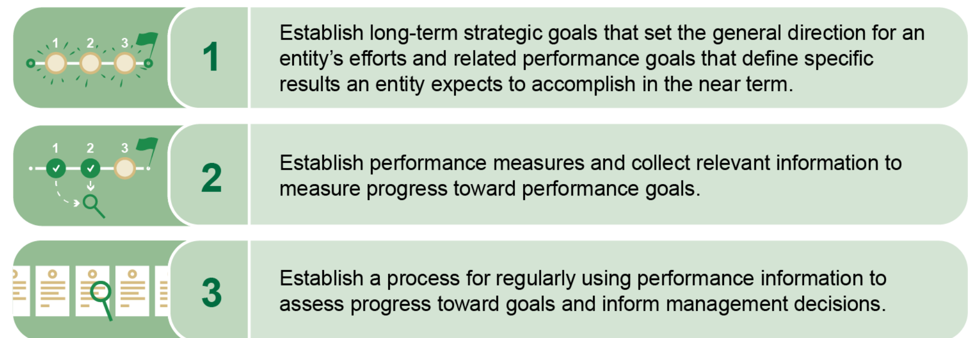
What GAO Found

The Office of the Medical Inspector's mission is to investigate concerns about the quality of health care provided by the Veterans Health Administration (VHA). The office conducts investigations in response to referrals from other Department of Veterans Affairs (VA) and VHA components, and the U.S. Office of Special Counsel, which stem from concerns raised by whistleblowers and others. Such concerns are typically clinical in nature, such as concerns about improper equipment sterilization. The office reported opening between 25 and 74 cases each fiscal year from 2017 through 2022. Its authorized staffing levels were 20 full-time employees in 2022, but three of those positions were unfilled. Nearly all completed cases during the 6-year period resulted in recommendations for corrective action, which were typically made to VHA health care facilities.

For any given case, a clinical program manager within the Office of the Medical Inspector is responsible for determining (1) whether proposed corrective actions adequately address recommendations, and (2) when the actions have been completed, according to officials. However, the office does not conduct supervisory review of these determinations. Doing so would provide greater assurance that the recommendations are implemented to fully address the underlying concerns.

GAO found the Office of the Medical Inspector has not assessed its overall progress toward meeting its mission. Specifically, the office has not taken the three key performance management steps (see figure).

Steps to Assess Progress toward Meeting Mission



Source: GAO; GAO (illustrations). | GAO-23-105634

Office of the Medical Inspector officials indicated that timeliness and quality are important factors in conducting their work. However, the office has not established goals and performance measures that define the specific results it expects to accomplish—for example, related to timeliness or quality of various aspects of the office's work. As a result, the office does not know to what extent it is meeting its mission. Furthermore, establishing performance information would allow VHA leadership to more fully understand and assess how the office's work complements that of other oversight offices and help better ensure collective oversight and accountability across VHA's vast health care system.

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Abbreviations

OMI	Office of the Medical Inspector
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
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July 27, 2023

Congressional Requesters

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the largest health care systems in the nation, serving about 9 million veterans annually. VA is responsible for providing veterans with timely and cost-effective access to needed health care services, and for ensuring the quality and safety of those services.[1]

VHA has several program offices to help oversee the health care services it provides. One of these offices is the Office of the Medical Inspector (OMI). Established in 1980, OMI is an integral part of VHA's oversight program, with a mission to independently investigate concerns about health care provided by VHA in order to monitor and improve the quality of that care to veterans.

With a staff of physicians, nurses, and others, OMI assigns teams to conduct investigations in response to referrals from several entities, such as the U.S. Office of Special Counsel.[2] OMI receives referrals to investigate concerns that are typically clinical in nature, such as concerns related to improper sterilization of equipment or delays in veterans' access to prescription medications at VHA health care facilities. Upon

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[1]VHA provides enrolled veterans with a full range of inpatient and outpatient services through VA medical centers, which typically provide primary care and some specialty care services, and their affiliated community-based outpatient clinics. Veterans Integrated Service Networks are responsible for managing and overseeing day-to-day functions of VA medical centers and other VHA health care facilities within their defined regional geographic areas.

[2]The U.S. Office of Special Counsel refers VA-related whistleblower allegations that it receives to the Secretary of Veterans Affairs, who assigns them to the appropriate VA administration for investigation. Whistleblowers can include current federal employees, former federal employees, and applicants for federal employment who report allegations of wrongdoing. Such allegations include those related to a violation of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; a substantial and specific danger to public health or safety; or censorship related to scientific research.

The Office of Special Counsel receives allegations involving VA related to whistleblower retaliation but these types of allegations are not referred to OMI for investigation. See GAO, *VA Whistleblowers: Resolution Process for Retaliation Claims,* GAO-23-106111 (Washington, D.C.: May 3, 2023).

receiving a referral that OMI determines warrants investigating, OMI opens a case. For each case, OMI is responsible for investigating the underlying issue and then producing written reports with its findings, conclusions, and recommendations for corrective actions as warranted. OMI is also responsible for conducting follow-up to determine whether recommendations have been implemented.

OMI's efforts to ensure veterans have access to quality care is especially important in light of our prior work, along with that of VA's Office of Inspector General and others, which has found that VA has faced challenges overseeing its health care system. These challenges have included VA's ability to hold its health care facilities accountable and manage risk, including ensuring the safety and protection of patients and staff through preventing adverse events and resolving identified problems in a timely and appropriate manner.[3]

You asked us to review how OMI carries out its responsibilities. In this report, we

1. describe OMI's caseload and staffing levels from fiscal years 2017 through 2022;
2. describe the frequency with which OMI cases from fiscal years 2017 through 2022 resulted in recommendations;
3. examine OMI's process for determining whether recommendations have been implemented; and
4. examine OMI's efforts to assess its performance.

To conduct our work, we reviewed relevant VHA documentation, including OMI's policies, mission statement, and standard operating procedures. We also interviewed or received written responses from OMI officials and officials from other relevant VA offices (e.g., VA's Office of Inspector General, VHA's Office of Oversight, Risk, and Ethics) to better understand OMI's roles and responsibilities and how it fits within VHA's

[3]As a result of these longstanding issues, GAO added VA health care to its High-Risk List in 2015. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015). GAO placed VA on GAO's High Risk List in 2015 due to challenges identified with the VA's ability to provide timely, cost-effective, and quality care. Areas of concern include inadequate oversight and accountability within VA and unclear resource needs and allocation priorities.

oversight and accountability efforts.[4] In addition, we interviewed officials from the U.S. Office of Special Counsel, an independent federal investigative and prosecutorial agency that refers cases to federal agencies, including the VA.

To describe OMI's caseload (the number of cases OMI opened) from fiscal years 2017 through 2022, we analyzed information OMI compiled on its cases for this time period.[5] We selected this timeframe because OMI officials said gathering comparable information for earlier years presented challenges due to changes in how they tracked case information over time. Information for fiscal year 2022 was the most recently available information at the time of our review. OMI officials manually compiled for us caseload information using spreadsheets they use to track open cases, as well as documents, such as referral letters and OMI reports.[6] The information OMI compiled included the referral source of each case, and key dates in their investigative process, including the referral date and the date its completed report was signed by the Secretary of Veterans Affairs. We assessed the reliability of OMI's case information by, for example, interviewing knowledgeable officials; examining the information for missing data or obvious errors; and comparing the information with other sources, where possible, for corroboration. On the basis of these steps, we determined that the information OMI compiled for us was sufficiently reliable for the purposes of reporting general information on the volume and sources of cases and the length of time to complete cases. For some analyses, we report approximate percentages and not underlying values to appropriately

[4]In addition, we also interviewed or received written responses from VA's Office of the Executive Secretary, VHA's Office of Internal Audit, VHA's Office of Integrity and Compliance, and VA's Office of Accountability and Whistleblower Protection.

[5]To identify cases for this time period, OMI officials used the date the referral was received by OMI, except for referrals from the U.S. Office of Special Counsel. For those referrals, which are first sent to the Secretary of Veterans Affairs before they are sent to VA components such as OMI, OMI used the date the Secretary of Veterans Affairs received the referral from the U.S. Office of Special Counsel. For purposes of this report and ease of reading, we refer to the case information provided by OMI as cases opened in any given fiscal year.

[6]OMI officials said they track the status of open cases by entering information related to individual cases into a spreadsheet. They said once a case is closed, they remove it from the spreadsheet. OMI officials said they reviewed weekly archived copies of the spreadsheet to compile the caseload information.

reflect the reliability of the information that was manually compiled by OMI.[7]

To describe OMI's staffing levels, we reviewed information from OMI about the positions that were authorized, filled, vacant, and unfunded, as of the end of each fiscal year from 2017 through 2022. We also interviewed officials from OMI, VHA's Office of Oversight, Risk, and Ethics, and VHA's Office of Human Capital Management, to understand who determines OMI's staffing levels.

To describe the frequency with which OMI's cases resulted in recommendations, we analyzed information that OMI manually compiled and included in its case information for fiscal years 2017 through 2022. Such information included the number of recommendations OMI made to various subjects (i.e., VHA health care facilities, regional networks, and VA and VHA program offices). We also reviewed information on the number of those recommendations that OMI determined had been implemented as of the dates OMI compiled the information, which were in September and October 2022.[8] We assessed the reliability of this information by taking the same steps described above and determined it was sufficiently reliable for the purposes of this reporting objective. We report approximate percentages and not underlying values to appropriately reflect the reliability of the information that was manually compiled by OMI for these analyses.

To examine OMI's process for determining whether recommendations have been implemented, we reviewed relevant documents, including OMI's standard operating procedures and position descriptions describing tasks OMI staff are expected to be able to perform. We examined whether OMI's process includes steps that are consistent with federal internal control standards—that is, whether the process includes a second level of supervisory review. We did not evaluate how effectively

[7]We identified small differences in how OMI counted referral and case information in comparison to how other sources, such as VA's Office of the Executive Secretary, tracked similar information. For example, in one instance, it appeared that OMI consolidated three referrals into one case, whereas the Office of the Executive Secretary, which assigns some referrals to OMI, tracked each of the three referrals separately.

[8]OMI compiled and sent its case information for fiscal years 2017 through 2022 in two batches, the first of which we received in September 2022 and the second in October 2022. As noted previously, the universe of cases OMI included was based on the date of referral. As a result, some cases did not yet have completed reports or recommendations at the time OMI compiled the data.

the process was implemented by OMI staff or the validity of their determinations.[9]

To examine OMI's efforts to assess its progress towards achieving its mission, we reviewed relevant documents, such as OMI's mission and VHA policy related to the role of OMI.[10] We also interviewed OMI officials to understand the office's efforts to assess its progress toward meeting its mission, such as by developing goals and measuring progress toward those goals. We compared this information to practices for performance management identified in our prior work and VHA policy related to VHA program office responsibilities.[11]

We conducted this performance audit from December 2021 to July 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Led by the Medical Inspector, OMI is responsible for conducting investigations in support of its mission to monitor and improve the quality of health care provided to veterans. The Medical Inspector reports directly to and is supervised by the Under Secretary for Health, who is the head of VHA. OMI has described its office as the eyes and ears of the Under Secretary for Health and stated it is to function as a rapid response team available to deploy on short notice to investigate emergent concerns as

[9]Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014).

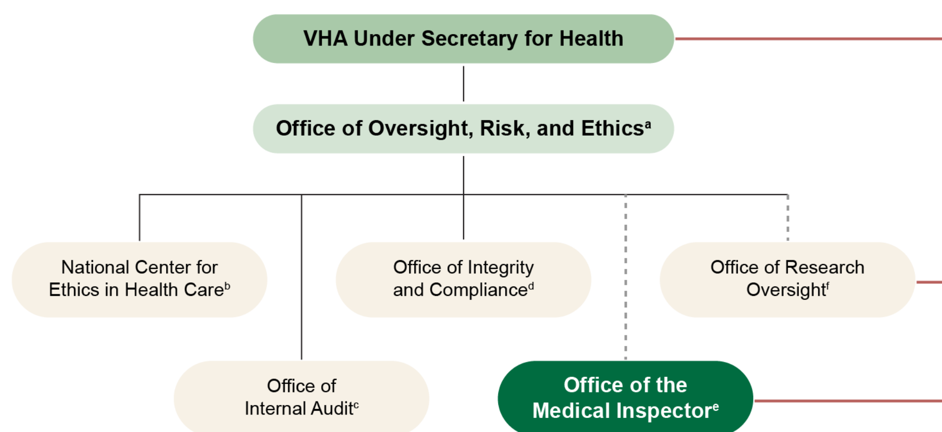
[10]Department of Veterans Affairs, *Role of the Office of the Medical Inspector,* VHA Directive 1038 (Washington, D.C.: Jan. 30, 2023).

[11]GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996); and *Managing for Results: Enhancing Agency Use of Performance Information for Management Decision Making,* GAO-05-927 (Washington, D.C.: Sept. 9, 2005). Department of Veterans Affairs, Veterans Health Administration, *VHA Central Office Operating Units*, VHA Directive 1217 (Washington, D.C.: Sept. 10, 2021).

directed by the Under Secretary for Health. In fiscal year 2022, OMI had a budget of about $5 million.

As of April 2023, OMI was aligned within VHA's Office of Oversight, Risk, and Ethics, along with several other oversight offices (see fig. 1). That office was responsible for providing national leadership; executing enterprise risk compliance, oversight, and ethics; and mitigating risks identified by the oversight offices aligned within it.[12] According to VHA officials, OMI's alignment within the Office of Oversight, Risk, and Ethics was administrative, meaning that the office assisted OMI with budget management and human resource issues.

Figure 1: VA's Veterans Health Administration (VHA) Oversight and Accountability Program Offices, as of April 2023



Source: Department of Veteran Affairs (VA). | GAO-23-105634

Notes: Under this oversight structure, the Office of the Medical Inspector (OMI) is aligned administratively within the Office of Oversight, Risk, and Ethics, as indicated by the dotted line. The Medical Inspector (head of OMI) reports to and is supervised by the VHA Under Secretary for Health, as indicated by the solid red line.

According to VA's 2021 Functional Organization Manual, the offices in this figure have the following responsibilities.

[a]Responsible for providing national leadership; executing enterprise risk compliance, oversight, and ethics; and mitigating risks identified by the oversight offices aligned within it.

[b]Responsible for addressing the complex ethical issues that arise in health care, including issues relating to clinical, organizational, and research ethics and making recommendations to promote strong ethics and professionalism standards.

[12]Department of Veteran Affairs, *Functional Organization Manual*, version 7 (2021).

[c]Responsible for serving as the principal advisor to VHA's Under Secretary for Health on all internal audit matters as well as providing national level independent and objective assurance to VHA senior leadership on the effectiveness of governance, risk management, and compliance and internal controls for health care operations and administrative functions.

[d]Responsible for providing guidance to VHA's Under Secretary for Health and other VHA leadership on integrity and compliance issues and supporting VA medical centers, VHA program offices, and others in their efforts to deter, detect, oversee, and address non-compliant activity in an effort to adhere to applicable laws, regulations, and policies.

[e]Responsible for assessing the quality of VA health care through investigations of VA facilities nationwide and producing reports with findings, conclusions, and recommendations for improvement.

[f]Responsible for advising VHA's Under Secretary for Health on matters of research compliance, and overseeing compliance with VA and other federal requirements for the protection of human research subjects, laboratory animal welfare, research safety, and other research-related matters.

In April 2023, VHA announced that it was beginning work to reorganize VHA's oversight and accountability program offices. Specifically, a VHA memo stated that OMI would continue to report directly to the Under Secretary for Health, but that VHA would sunset the Office of Oversight, Risk, and Ethics and realign its functions elsewhere. However, VHA officials further told us in May 2023 that it was too early to say how the organizational changes could affect the composition or responsibilities of OMI. The officials said that they expect to complete implementation of the reorganization in early fiscal year 2024.

Referral Sources

OMI does not initiate work on its own.[13] Instead, OMI's caseload is based on referrals it receives from other VA and VHA components and the U.S. Office of Special Counsel to investigate allegations related to specific health care concerns raised by whistleblowers and others, as described in table 1.[14] OMI officials said they generally accept referrals they receive

[13]According to a 2014 document proposing options for restructuring its office that OMI prepared for the Acting Secretary of Veterans Affairs, OMI at that time conducted national quality assessments on its own initiative or as assigned by the Secretary of Veterans Affairs or Under Secretary for Health. These were systematic analyses of VHA health data and other information that OMI used to advise VHA leadership about system-wide issues affecting the quality of VHA health care, according to the 2014 document. However, OMI officials said they stopped doing these assessments as a result of the restructure in 2014.

[14]The origins of referrals can include VA whistleblowers; members of Congress in response to information received from constituents, veterans service organizations, or media reports of problems at certain VA medical facilities; and VA employees and the general public who submit complaints to the VA Office of Inspector General's complaint hotline.

that are appropriate for OMI investigation, and they refer to referrals that they accept and investigate as cases.[15]

Table 1: Referral Sources for Office of the Medical Inspector (OMI) Investigations

Source	Referrals
U.S. Office of Special Counsel[a]	Refers Department of Veterans Affairs (VA) related whistleblower allegations of wrongdoing to the Secretary of Veterans Affairs. Such allegations include those related to a violation of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; a substantial and specific danger to public health or safety; or censorship related to scientific research. The Secretary of Veterans Affairs then assigns referrals to the appropriate VA administration for investigation. According to VA officials, for any Office of Special Counsel referral that is ultimately assigned to OMI, the VA Office of Inspector General had the first right of refusal and declined to investigate it.
Secretary of Veterans Affairs	May charge the Veterans Health Administration (VHA) Under Secretary for Health to direct OMI to investigate allegations received by the Secretary of Veterans Affairs in response to concerns raised by members of Congress in response to information received from constituents, veterans service organizations, or media reports of problems at certain VA medical facilities.
VHA Under Secretary for Health	May direct OMI to investigate a concern the Under Secretary for Health has identified at a VA medical facility, within a regional network, or a VHA program office.
VA Office of Accountability and Whistleblower Protection[b]	May refer whistleblower allegations it receives that are outside the scope of its authority to conduct investigations (i.e., those not related to whistleblower retaliation or senior leader misconduct or poor performance). Referred allegations may include those related to a violation of law, an abuse of authority, mismanagement, or a substantial and specific danger to public health or safety. According to VA officials, for any referral that this office ultimately sent to OMI, the VA Office of Inspector General had the first right of refusal and declined to investigate it.
VA Office of Inspector General	May refer allegations from the hotline it manages for receiving allegations and complaints from VA employees and the general public that warrant further action. Referred allegations may include those related to a violation of law, an abuse of authority, gross mismanagement, or a substantial and specific danger to public health or safety related to VA's programs and operations.

Source: VA and VHA. | GAO-23-105634

[a]The U.S. Office of Special Counsel is an independent federal investigative and prosecutorial agency that reviews allegations of wrongdoing from whistleblowers, which can include current federal employees, former federal employees, and applicants for federal employment in federal government agencies.

[b]The Office of Accountability and Whistleblower Protection receives whistleblower disclosures from VA employees and applicants for VA employment. If such disclosures do not involve whistleblower retaliation or senior leader misconduct or poor performance, the Office of Accountability and Whistleblower Protection refers them to another component within VA, such as OMI, for investigation.

VA's Office of Inspector General officials said that they can do similar work as OMI in terms of investigating quality of clinical care concerns.

[15]OMI officials said that they accept almost all U.S. Office of Special Counsel referrals. For referrals from other sources, OMI officials said they may decline a referral if it relates to an issue or topic that is beyond their area of expertise or if they are already in the process of investigating a case with the same or similar allegations from a different referral source. Officials also said they may also occasionally recommend that a Veterans Integrated Service Network or another program office review a concern if it is more appropriate for a local investigation.

However, they may decline referrals from other sources, which may subsequently be sent to OMI, or make referrals directly to OMI if they choose not to open a case. They said they may do this if they recently conducted work on a related topic, there is insufficient information available to allow them to conduct a meaningful review, or they feel the referral is better suited to OMI. VA's Office of Inspector General officials said they communicate with OMI about monthly to discuss their respective caseloads, update each other on any clinical cases or site visits they are conducting, and prevent duplication of efforts between the two offices.[16]

OMI Cases

OMI is responsible for taking the following steps for each of its cases:

Opening a case. Once OMI receives a referral that it determines warrants opening a case, OMI leadership assigns an investigative team that typically includes a senior medical investigator (i.e., a licensed physician), a clinical program manager (i.e., licensed registered nurse), subject matter experts as needed, and other staff.[17] The assigned senior medical investigator and clinical program manager are responsible for preparing for the investigation by reviewing allegations, gathering pertinent background information, and coordinating the investigation.

Conducting a site visit. OMI officials said that all cases include a site visit that occurs within a VHA health care facility and that site visits can be conducted onsite, virtually, or a combination of both.[18] As part of each investigation, the team is responsible for interviewing VHA health care facility staff and leadership. The team is also responsible for visiting or examining areas of interest as needed to investigate allegations and

[16]According to statute, VA Office of Inspector General's activities include overseeing OMI. VA Office of Inspector General officials told us that the two offices operate independently from one another, but that the VA Office of Inspector General oversees OMI as it does other VA programs and operations. *See* Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322 § 201(a)(4), 102 Stat.487, 508 (1988).

[17]OMI officials said they may supplement investigative teams with subject matter experts, as needed, from VA's Central Office, program offices, or VA medical centers. OMI officials told us that the extent to which investigative teams rely on subject matter experts varies depending on the topic and complexity of cases.

[18]Site visits can either be unannounced (in which the site is not notified of the investigation before the OMI team arrives) or announced (in which the site is notified of OMI's investigation beforehand).

reach preliminary findings, conclusions, and recommendations as warranted.

Sharing preliminary findings. At the end of the investigation, OMI is responsible for sharing its preliminary findings, conclusions, and recommendations with VA health care facility leadership and informing them of any findings that may require immediate attention. Following the investigation, the team is responsible for debriefing the Medical Inspector within 3 working days or at a mutually agreed upon time. At the debrief, the team is responsible for presenting its preliminary findings, conclusions, and recommendations as warranted, and preparing the Medical Inspector to brief the VHA Under Secretary for Health regarding the results of the investigation. (See text box for more detail on the Medical Inspector's briefings to the Under Secretary.)

Medical Inspector Briefings to Veterans Health Administration (VHA) Leadership

Before the Office of the Medical Inspector (OMI) completes a report, the Medical Inspector (who leads OMI) is responsible for briefing the Under Secretary for Health and other select members of VHA leadership about the case. OMI officials said these briefings occur biweekly, and for each briefing, OMI prepares a summary of the case that includes information such as the referral source, the nature of the allegations, the dates of the site visit, and OMI's preliminary findings, conclusions, and any recommendations (including recommendations that may have system-wide implications for VHA).

OMI officials said that they do not have a designated full-time equivalent employee with the subject matter expertise to systematically analyze trends and patterns across cases to proactively identify potential health care issues across the VHA health care system. However, they said they report potential systemic issues that were uncovered in the course of OMI's investigations to the Under Secretary for Health and other VHA leadership. For example, OMI officials briefed the Under Secretary for Health and other VHA leadership about an investigation that found that a VHA health care facility did not consistently have the minimum number of trained staff working in its magnetic resonance imaging area, which is important for ensuring safety. OMI officials said that this investigation led to the identification of system-wide implications and helped inform a VHA-wide policy regarding appropriate staffing levels in magnetic resonance imaging areas.

Source: Veterans Health Administration (VHA) Office of the Medical Inspector (OMI). | GAO-23-105634

Preparing a report. Investigative team members are also responsible for completing an initial draft report that includes OMI's findings, conclusions, and any warranted recommendations resulting from the investigation so it

can be submitted for review and comment by a review panel.[19] According to OMI officials, the purpose of the review panel is to make sure the report uses correct terminology, is easy to read, and the evidence supports the findings, conclusions, and recommendations. After incorporating any changes resulting from the review panel, the draft report is to be sent to OMI leadership for review. Following leadership review, the Medical Inspector is responsible for approving the draft report to go through a concurrence process that includes several VHA leaders and VA program offices.[20] According to OMI officials, the purpose of the concurrence process includes making sure legal information in the report is appropriate and sound, ensuring references to documents are valid, and making sure the writing is grammatically correct and the report follows the VA style guide.

Submitting report for signature and distributing report to Congress. After the concurrence process is complete for each case, the Medical Inspector is responsible for submitting the associated report to the VHA Office of Executive Correspondence, who is then responsible for submitting it to the VA Office of the Secretary for the Secretary of Veterans Affairs' signature. Upon receipt of the Secretary of Veterans Affairs' signature, the VA Office of Congressional and Legislative Affairs is responsible for distributing final reports to the Chairs and Ranking Members of the Senate and House Committees on Veterans Affairs.[21]

[19]The review panel consists of representatives from the Office of the Associate Deputy Under Secretary for Health for Oversight, Risk, and Ethics, the Office of the Assistant Under Secretary for Health for Clinical Services, the Office of the Assistant Under Secretary for Health for Patient Care Services, the National Center for Ethics in Health Care (an office under the Office of Oversight, Risk, and Ethics that is responsible for addressing issues related to clinical, organizational, and research ethics), subject matter experts, and VA's Office of General Counsel, as needed.

[20]The concurrence process entails reviews of OMI's final report by the VA Office of General Counsel; Assistant Under Secretary for Health for Clinical Services; Assistant Under Secretary for Health for Operations; VA Office of Congressional and Legislative Affairs; Associate Deputy Under Secretary for Health Oversight, Risk, and Ethics; Assistant Under Secretary for Health for Patient Care Services; and VHA Office of Executive Correspondence.

[21]According to VA officials, the public can request copies of OMI reports through the VHA Freedom of Information Act Office. According to U.S. Office of Special Counsel officials, OMI reports issued in response to formal U.S. Office of Special Counsel referrals are publicly available in redacted form on the U.S. Office of Special Counsel website; see https://osc.gov/PublicFiles.

Certain OMI cases have deadlines for submitting reports. Specifically, by statute, for cases based on referrals from the U.S. Office of Special Counsel, VA is to submit a report to that office on the results of its investigation within 60 days of the date that VA received the referral. However, the U.S. Office of Special Counsel may grant extensions to these deadlines.[22] In addition, OMI officials said that while most of the cases based on referrals from VA's Office of Inspector General do not have a deadline, that office may also request that OMI complete a report within a specific timeframe (e.g., 60 days) for certain cases.

Closing a case. For cases that include recommendations, OMI is responsible for ensuring that a copy of the report and an action plan template is sent to the subject responsible for addressing each recommendation. A single report may include recommendations directed to one or more subjects, which may include the VHA health care facility that was the subject of the investigation, a Veterans Integrated Services Network, a VHA program office, or a VA program office. Each subject is expected to respond to OMI within 30 days of receiving the report, indicating the corrective actions it plans to take to address each recommendation. Once OMI determines that all corrective actions have been successfully completed, the Medical Inspector is responsible for notifying VHA's Under Secretary for Health and recommending that the Under Secretary close the case.[23] Following this notification, the Under Secretary for Health is responsible for signing a memo indicating the case has been closed.

[22]By statute, federal agencies, including VA, are to submit a report to the U.S. Office of Special Counsel within 60 days of the date they were sent the referral unless the federal agency requests an extension and it is agreed to in writing by the Office of Special Counsel. See 5 U.S.C. § 1213(c)(1)(B). Referrals to agencies can be either formal or informal. Formal referrals are those in which the U.S. Office of Special Counsel determined there is a substantial likelihood that the allegation(s) occurred and are subject to certain statutory requirements. Informal referrals are those in which they determined the allegations are less egregious in nature. Informal referrals are not subject to statutory requirements; however, like formal referrals, they have a 60-day due date that can be extended through extension requests.

[23]OMI officials said that they do not specify when they expect subjects to implement the recommendations. They said that subjects may complete corrective actions within a few months while others, such as those related to the construction or renovation of facilities, can take several years to complete.

OMI's Reported Caseload Varied from Fiscal Years 2017 through 2022, While Staffing Increased Initially and Then Remained Level

OMI's Reported Annual Caseload Ranged from 25 to 74 Cases, Driven by Referrals from Various Sources

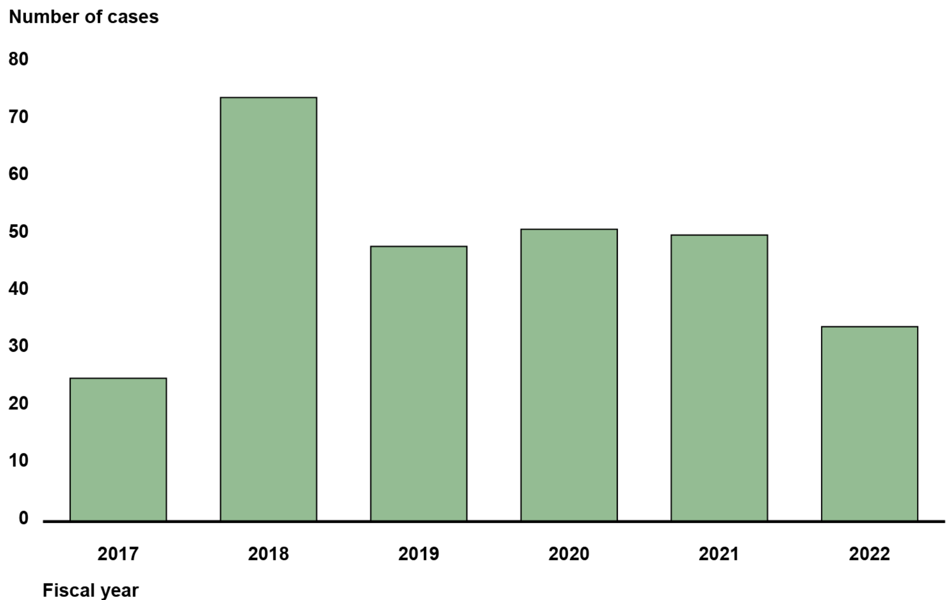
OMI's caseload is driven by the referrals it receives, which varied each year from fiscal years 2017 through 2022, according to information compiled by OMI officials. Caseload numbers represent the number of cases opened (but not necessarily completed) in any given fiscal year.[24] In fiscal year 2017, OMI reported opening 25 cases, then in the following fiscal year, its cases increased to 74, the highest number during this 6-year time period.[25] OMI's caseload then hovered around 50 cases per year over the next three fiscal years before declining to 34 cases in fiscal year 2022.[26] (See fig. 2.)

[24]Caseload numbers reflect cases newly opened each fiscal year; they do not include existing cases OMI had ongoing from prior fiscal years.

[25]According to information compiled by OMI officials, the increase in cases in fiscal year 2018 was driven by an increase in referrals from the U.S. Office of Special Counsel. An official from the Office of Special Counsel did not attribute its increase in referrals to VA in fiscal year 2018 to any particular reason, explaining that the number of referrals made to a federal agency in any given year is solely determined by whether the Office of Special Counsel's review of a whistleblower disclosure finds a substantial likelihood of wrongdoing.

[26]OMI does not have a system to track its cases from year to year. OMI manually compiled this information for fiscal years 2017 through 2022, based on information it maintains in individual files and documents.

Figure 2: VHA's Office of the Medical Inspector Reported Caseload, Fiscal Years 2017–2022



Source: GAO analysis of Veterans Health Administration (VHA) Office of the Medical Inspector information. | GAO-23-105634

Note: The number of cases represent referrals received in each fiscal year that were accepted and opened by VHA's Office of the Medical Inspector (OMI), as compiled and reported to us by OMI. If a case was open over 2 or more fiscal years, OMI only counted it in the fiscal year in which the referral was received.

The majority of OMI's cases from fiscal years 2017 through 2022 came from two sources that receive allegations from whistleblowers, including VA employees. According to the information compiled by OMI, the U.S. Office of Special Counsel and VA's Office of Accountability and Whistleblower Protection together accounted for over 80 percent of OMI's total caseload during the time period.[27] After 2018, the portion of OMI's caseload from the U.S. Office of Special Counsel decreased each year. In contrast, the caseload from VA's Office of Accountability and Whistleblower Protection, which was established in 2017, increased until 2022. As a result, by fiscal year 2021, OMI reported receiving more cases from the Office of Accountability and Whistleblower Protection than from the Office of Special Counsel. An OMI official said that this change could have been the result of whistleblowers becoming more educated about and comfortable with reporting their concerns internally, such as directly

[27]For this and other similar analyses on caseload, we report approximate percentages to appropriately reflect the reliability of the information that was manually compiled by OMI.

to VA's Office of Accountability and Whistleblower Protection, rather than going outside of the agency to the U.S. Office of Special Counsel.

In comparison, a smaller proportion (about 11 percent) of OMI's reported caseload from fiscal years 2017 through 2022 came from the Secretary of Veterans Affairs or VHA's Under Secretary for Health.[28] In fiscal year 2022, the portion of OMI's reported caseload that came from the Under Secretary for Health was higher than it had been in any of the 4 prior fiscal years.

OMI officials said they prioritize their cases based on the nature of the allegations. Officials said they can receive allegations of varying sensitivity and complexity from the different sources that send them referrals. They then prioritize their work, depending on the nature of the case. For example, OMI officials said if they receive an urgent, high priority case (e.g., one indicating immediate or serious patient or staff harm), OMI staff can shift their priorities and deploy to the site within a few days. Officials noted, however, that shifting priorities to respond to an urgent case can slow OMI's progress on less urgent cases.

Our analysis of OMI caseload information from fiscal years 2017 through 2022 found that OMI took on average about 8 months to complete cases.[29] Cases from the U.S. Office of Special Counsel have a due date of 60 days, but officials from the U.S. Office of Special Counsel said that, similar to other VA components and federal agencies, OMI typically requests extensions to complete reports.

The length of time it takes OMI to complete cases can be affected by a variety of factors, according to OMI officials. They said such factors include the scope and number of allegations related to each case; travel logistics; the availability of OMI staff and subject matter experts; and the availability of the whistleblower (if known) and other key staff to be interviewed. In addition, OMI staff noted that several other VA offices have to review and concur with their reports and they cannot control how long it takes these offices to do this.

[28]The remainder of OMI's reported caseload during fiscal years 2017 through 2022 came from VA's Office of Inspector General, with the exception of one case, which was referred by members of Congress, according to OMI officials.

[29]This time period reflects the length of time between the referral date and the date the Secretary of Veterans Affairs signed the report.

OMI's Authorized Staffing Increased to 20 Staff in Fiscal Year 2019 and Remained Unchanged through Fiscal Year 2022, with Some Positions Unfilled

Based on our review of OMI information, we found that OMI's authorized staffing levels initially increased from 16 to 20 full-time equivalent employees from fiscal years 2017 to 2019, then remained at 20 full-time equivalent employees through fiscal year 2022. In fiscal year 2022, OMI's 20 authorized full-time equivalent positions included

- the Medical Inspector, one chief medical investigator, and three senior medical investigators (all of whom were licensed physicians);
- one chief clinical program manager and seven clinical program managers (all of whom were licensed registered nurses); and
- seven support staff (such as a technical writer-editor and correspondence analyst).

Not all of OMI's authorized positions, however, were filled or funded from fiscal years 2017 through 2022. Specifically, each year during this time period, between two and four of OMI's authorized positions were either vacant or unfunded (see table 2). According to VHA officials, vacant positions are positions that have been funded but are not filled, whereas unfunded positions are those for which there is an established need but have not been funded due to funding being reallocated elsewhere or budget constraints.

Table 2: Staffing for VHA's Office of the Medical Inspector, Fiscal Years 2017–2022, in Full-Time Equivalent Employees

	Number of full-time equivalent employees (as of the end of each fiscal year)					
	2017	2018	2019	2020	2021	2022
Total authorized	16	17	20	20	20	20
Filled	13	14	18	16	16	17
Vacant (funded)	3	3	2	3	3	1
Unfunded	0	0	0	1	1	2

Source: Veterans Health Administration (VHA), Office of the Medical Inspector. | GAO-23-105634

Note: Vacant (funded) positions are authorized and budgeted for but not filled. Unfunded positions are authorized but not budgeted and therefore not filled.

OMI officials said that as of the end of fiscal year 2022, the office was currently right-sized with respect to physician staff given their workload. However, the officials noted that ongoing challenges filling other authorized positions had resulted in interruptions to and delays in

conducting their work.[30] For example, OMI officials told us it had been difficult to fill a technical writer-editor position because they had not been able to find and keep a qualified candidate at the pay grade the position offers. They said this vacancy resulted in delays in moving cases through the report concurrence process. OMI officials also noted that an authorized position for a correspondence analyst position had not been funded since 2018 due to budget constraints.[31] This position, among other things, is responsible for overseeing the production, formatting, and editing of reports and creating, responding, and tracking all correspondence to and from the office. Officials said that OMI staff in leadership roles had to balance their workloads to fulfill these additional responsibilities, which created delays in OMI's day-to-day operations as well as completing reports.

Use of Subject Matter Experts by VHA's Office of the Medical Inspector

According to officials from VHA's Office of the Medical Inspector (OMI), investigative teams rely on different types of subject matter experts depending on individual case needs. For example, OMI officials said they have enlisted subject matter experts from VHA's Sterile Processing Services for cases involving sterility issues in operating rooms and a psychologist for cases involving patient suicides. One official from another VHA oversight office said OMI has become skilled at identifying and enlisting subject matter experts to supplement its resources and help conduct its work.

Source: Veterans Health Administration (VHA). | GAO-23-105634

In addition, OMI officials told us they have had internal discussions as to whether to seek authorization for an additional clinical program manager. They said that clinical program managers organize and oversee most aspects of the OMI's work processes, including, for example, ensuring the investigative team has the right subject matter experts on board, identifying appropriate individuals at the VHA health care facility to interview, drafting the initial report findings, and tracking the implementation of any recommendations. As such, OMI officials said receiving authorization for another clinical program manager would help OMI complete reports more quickly, but they would need data to support such a request. However, OMI officials told us in May 2023 that they have not yet sought authorization for funding for an additional clinical program manager or other positions. They explained they were waiting on further guidance as to how VHA's reorganization of its oversight program offices announced in April 2023 could affect OMI.

[30]In late fiscal year 2022, OMI officials said they filled a vacant senior medical investigator position (i.e., physician) that had not been permanently filled since January 2020. Officials noted the delay in filling this position had increased the workload of the Medical Inspector and other senior medical investigator staff. In addition, in fiscal year 2022, OMI's chief medical investigator was not available full-time to OMI, as this staff person was also serving in an acting leadership position in VHA's Office of Oversight, Risk, and Ethics.

[31]According to OMI officials, the correspondence analyst position was authorized, but because OMI's budget was not sufficient to cover the costs of this position, they did not fill the position.

Nearly All OMI Cases from Fiscal Years 2017 through 2022 Resulted in Recommendations, with Most Directed to VHA Health Care Facilities

Our analysis of OMI information found that nearly all of its completed cases from fiscal years 2017 through 2022 resulted in recommendations. Specifically, we found that about 95 percent of OMI's completed cases resulted in at least one recommendation, with an average of about eight recommendations per report.[32] Our analysis showed that OMI directed about 85 percent of its recommendations to VHA health care facilities; about seven percent to a Veterans Integrated Services Network; almost seven percent to a VHA program office; and the remainder to a VA program office or other entity.

OMI's recommendations during the 6-year time period ranged in their focus and scope, depending on the nature of each case and OMI's associated findings. A single case could have resulted in recommendations directed to multiple levels within VA, such as to the VHA health care facility that was the subject of the investigation as well as other entities within VA. See figure 3 for examples of OMI cases and recommendations.

[32]For analyses about recommendations, we present the approximate percentages to appropriately reflect the reliability of the information OMI manually compiled. We based our analysis on cases with completed reports that had been signed by the Secretary of Veterans Affairs as of the date OMI compiled the information for us in September and October 2022. At that time, OMI had not yet completed reports for 1 of 50 cases that were opened in fiscal year 2021 and 24 of 34 cases opened in fiscal year 2022.

Figure 3: Examples of Office of the Medical Inspector (OMI) Case Findings and Recommendations

Patient scheduling practices at a VHA health care facility

Findings

In fiscal year 2017, OMI substantiated whistleblower allegations that employees at a VHA health care facility's affiliated clinics had engaged in improper scheduling practices based on self-reported "zeroed-out" patient wait times. A zero wait-time occurs when an appointment takes place on either the same date that the Department of Veterans Affairs (VA) health care provider determined it was clinically appropriate or the date the patient preferred to be seen. VA's goal is to schedule all outpatient appointments to occur no more than 30 calendar days from either of those dates. According to OMI, based on historical data, a high incidence of appointments being completed on either of those two exact dates is unlikely and suggestive of improper scheduling practices. OMI found that the medical support assistants scheduling appointments had engaged in improper scheduling practices but without malicious intent. OMI also found that required monthly audits of medical support assistants were not being completed on a regular basis.

Recommendations

OMI recommended that the VHA health care facility, among other things, conduct additional training for the medical support assistants and develop and implement a more robust auditing process of scheduling practices at each of its affiliated clinics.

OMI recommended that the Veterans Integrated Services Network that oversees the VHA health care facility develop and conduct a robust audit and analysis of the VHA health care facility's scheduling practices to identify training successes or failures and pinpoint locations in need of specific training.

Physician shortages in a VHA health care facility

Findings

In fiscal year 2020, OMI substantiated several whistleblower allegations and found that **(1)** a VHA health care facility had a significant shortage of physicians in several service lines including dermatology, gastroenterology, oncology, and others, which impedes access to care; **(2)** because of the physician shortage, patients were often referred to non-VA providers in the community; and **(3)** the VHA health care facility's community care office was overwhelmed with the volume of referrals for non-VA care.

Recommendations

OMI recommended that the VHA health care facility, among other things, establish a physician exit interview process and trend factors that influenced physician departures; recruit for a permanent medical director for the community care program; and identify staffing needs for the community care program to increase overall productivity.

OMI recommended that the Veterans Integrated Services Network that oversees the VHA health care facility, among other things, collaborate with the VHA to conduct an intense recruitment and hiring strategy for a highly qualified chief of staff for the facility; conduct a gap analysis of current services offered at the VHA health care facility compared to other similarly designated facilities; and define the scope of services that can be consistently offered at the VHA health care facility.

OMI recommended that VHA, among other things, prioritize and oversee the recruitment and hiring of a highly qualified permanent chief of staff for the VHA health care facility; and determine the appropriate operative complexity level for the facility to successfully function, and realign resources accordingly.

Source: GAO (summary); Veterans Health Administration (VHA) (information); GAO (illustrations). | GAO-23-105634

Regarding recommendation implementation, OMI information showed that nearly 100 percent of its recommendations from cases opened in fiscal years 2017 through 2019 were determined to have been

implemented, as of September or October 2022, when OMI compiled the information. For cases opened in fiscal years 2020 through 2022 that were completed, OMI determined that about 67 percent of its recommendations had been implemented.

OMI's Process for Assessing Recommendation Implementation Does Not Include Supervisory Review

OMI officials said that OMI's process for determining whether its recommendations have been implemented is based on the successful completion of approved action plans by the subjects of the recommendations. In determining whether a recommendation has been implemented, the clinical program manager assigned to a case is responsible for making two key decisions, according to officials.

First, the clinical program manager is responsible for reviewing the action plan submitted by the subject of an OMI recommendation and determining whether the proposed corrective actions, if implemented, would adequately address the recommendation. If the clinical program manager determines they will not, the manager may request changes to the plan. Once the clinical program manager determines that the action plan will address the recommendation, the subject of the recommendation is responsible for providing updates on the status of the corrective actions at least every 90 days.

Second, OMI officials said the clinical program manager is responsible for reviewing the status of corrective actions and determining when all corrective actions in the action plan have been successfully completed. Officials told us that OMI considers the recommendation implemented once the clinical program manager receives documentation showing that all corrective actions have been completed and the subject of the recommendation demonstrates it can sustain the actions needed for improvement. For example, officials said that if OMI recommended that a facility educate staff on a particular topic, and the facility stated in its action plan that it was going to conduct a day-long training on this topic, OMI would request evidence that the training occurred such as copies of the training agenda, sign-in sheets, and any training certificates issued. OMI might also request that the facility conduct audits in the future to show the action was sustained and to confirm that the facility was addressing any issues as they arise. Once corrective actions have been

completed and are sustained, OMI officials said they would stop tracking actions taken by the subject.[33]

Our review shows that while OMI has a process for determining whether recommendations have been implemented, OMI officials told us that the decisions made by the clinical program manager do not receive supervisory review, such as from the office's Chief Clinical Program Manager or the Medical Inspector. OMI officials told us that the clinical program manager may consult with others (e.g., senior medical investigators and subject matter experts who participated in the investigation) if the manager needs additional expertise to help determine whether an action meets the intent of a recommendation, but it is at the clinical program manager's discretion to do so.[34]

OMI's process for assessing actions planned and taken in response to recommendations—a critical part of OMI's investigative process—relies exclusively on one individual to determine when the subjects of its recommendations have taken sufficient action to adequately address the recommendations. This is inconsistent with federal standards for internal control, which indicate that key duties and responsibilities should be divided among people within an organization to reduce the risk of error, misuse, or fraud and not have one individual control all key aspects of an event.[35] To be consistent with federal internal control standards, sufficient segregation of duties would entail OMI having a second level of supervisory review over the clinical program manager's decisions to

[33]OMI officials said that the subject of the recommendation is then responsible for ensuring continued compliance with the recommendation and often a VHA or VA program office will get involved to ensure compliance is maintained.

[34]According to OMI officials, once the clinical program manager determines that the subjects of OMI's recommendations have successfully completed corrective actions for all recommendations, OMI's administrative specialist prepares a closure package. The package includes a memo from the Medical Inspector to VHA's Under Secretary for Health recommending the case be closed, and a second memo from the Under Secretary for Health to the Assistant Under Secretary for Health for Clinical Services and Associate Deputy Under Secretary for Health, Oversight, Risk and Ethics advising them of the Under Secretary's decision that corrective actions are accepted as completed. OMI officials said that the Medical Inspector and the Under Secretary for Health do not receive additional documentation explaining the clinical program manager's decisions before completing these steps and do not provide a substantive level of review over the clinical program manager's decisions. However, in response to this report, VA stated that the Medical Inspector reviews all documents in the closure package and that the package includes the action plan and supporting documents.

[35]GAO-14-704G.

approve action plans and determine whether they were successfully completed. Furthermore, the procedures for this supervisory review should be documented. Federal internal control standards state that management should implement control activities through its policies, such as documenting its employees' responsibilities in policies. To be consistent with these standards would entail OMI documenting that supervisory review over the clinical program manager's decisions is a part of its process for assessing whether a recommendation has been implemented.

OMI officials said that recommendation review responsibilities are in accordance with the clinical program managers' position description.[36] However, even if clinical program managers have been delegated responsibility to make these decisions, it is important that they receive a second level of supervisory review to ensure consensus and that the procedure is documented to ensure consistency across these decisions. OMI's recommendations address deficiencies that can have implications for veterans' health care and patient and employee safety. As such, determining whether subjects' proposed corrective actions meet the intent of the recommendation as well as determining that they have been successfully completed is a key responsibility. A second level of supervisory review over these significant decisions would minimize the risk of error or misuse and provide OMI officials greater assurance that the recommendations are implemented to fully address the underlying concerns.

[36]The clinical program manager's functional statement includes a description of the tasks a person in the position should be able to perform. It notes that the clinical program manager has authority to speak for the Medical Inspector and participates with VHA and Veterans Integrated Services Network leadership, VHA health care facility staff, and others in the development of action plans to correct deficiencies and improve health care practices. Clinical program managers also serve as the chief spokespersons and investigative leads for site visits and are responsible for examining health care quality issues, adverse patient events, and protected whistleblower disclosures at VHA health care facilities.

OMI Monitors Open Cases, but Has Not Taken Steps to Assess Progress toward Meeting Its Mission

OMI officials told us they track the status of their open cases and said they review this information on an ongoing basis to look for ways to be more efficient and effective in their work processes. However, we found that OMI has not taken steps to formally assess the office's overall progress towards meeting its mission: to investigate concerns about the health care provided by VHA to monitor and improve the quality of care provided to veterans.

OMI officials told us they track the status of open cases by entering information related to individual cases into a spreadsheet. This information includes a short description of the allegations and key dates such as the referral, site visit, panel review, concurrence, and report signature dates. Officials said they review this information on a regular basis to monitor the status of open cases and how long cases are taking to complete. They said they discuss what they are seeing in the tracking spreadsheet during OMI's weekly case conference meeting where staff conduct a clinical and administrative review of each open case. OMI officials said they use this information to get a general sense of how things are going in terms of the timeliness of their investigations and reports and to identify any need for efficiency improvement.

In addition, in November 2022, OMI officials told us that they had started to explore new ways to use case information to identify opportunities to be more efficient and to reduce the number of requested extensions needed to complete reports. For example, officials said they are reviewing completed cases to see if there are any correlations between certain case characteristics (e.g., complexity of subject matter, the number and type of allegations) and the length of time it took to complete cases. Officials said they were developing their analyses as of May 2023 and it was too early to report any results. However, they noted that identifying correlations could help them predict what resources may be needed for new cases. For example, they said it could help them identify whether to staff a new case with one or two clinical program managers. OMI officials also said these efforts could help them support any future requests for additional resources, such as hiring additional staff. Officials explained that this would be helpful because they would need evidence to support such a request.

However, OMI has not taken steps to formally assess its progress toward meeting its mission.[37] Specifically, OMI has not taken the following three key performance management steps that we have identified in our prior work.[38] These steps are important for helping agencies measure and assess progress towards meeting their missions:

- **Step 1:** Working with stakeholders to define expected accomplishments by establishing long-term strategic goals that set the general direction for an entity's efforts and related performance goals that define the specific results an entity expects to accomplish in the near term;[39]
- **Step 2:** Establishing performance measures (based on objective, observable conditions) and collecting relevant information to measure progress toward performance goals; and
- **Step 3:** Establishing a process for regularly using performance information to assess progress toward goals and inform management decisions.

For example, OMI officials have indicated that timeliness is an important factor in doing their work, noting that delays in the correction of potential issues pose a risk to OMI achieving its mission to improve quality of care.

[37]The Medical Inspector has an annual personal performance plan that includes requirements that apply to a given performance period and can change over time. For example, one requirement is that the Medical Inspector identify and continue to enhance partnerships with stakeholders across federal agencies. The Under Secretary for Health, who supervises the Medical Inspector, uses the plan to assess the Medical Inspector's performance. However, we have previously reported that individual performance and organizational performance are two separate components of effective performance management systems, although the two should be aligned. See, GAO, *Results-Oriented Cultures: Creating a Clear Linkage between Individual Performance and Organizational Success,* GAO-03-488 (Washington, D.C.: Apr. 4, 2003).

[38]GAO/GGD-96-118. In this guide, we identified three key steps and additional practices within each step that federal agencies can implement to improve their overall performance. While the Government Performance and Results Act is applicable to the department or agency level (e.g., VA), we have previously reported that goals and performance measures are important management tools at all levels of an agency, such as component agencies, offices, programs, and projects. For example, see GAO, *Department of Justice: Actions Needed to Better Track and Monitor Responses to Congressional Correspondence*, GAO-23-105231 (Washington, D.C., Nov. 2, 2022).

[39]In the case of OMI, stakeholders may include the Under Secretary for Health and other offices that jointly with OMI are responsible for VHA's oversight system. We have previously reported that it is important for entities to involve stakeholders when establishing goals because it helps ensure that an entity's efforts and resources are targeted at the highest priorities. See GAO/GGD-96-118.

Officials have also noted the importance of balancing timeliness with producing high-quality reports that are based on thorough investigations and contain accurate findings, valid conclusions, and actionable recommendations as warranted. However, because OMI has not established strategic and performance goals, it is not clear what OMI expects to accomplish. To the extent timeliness and the quality of various aspects of OMI's work, such as developing findings, writing reports, and reviewing corrective actions are important factors in meeting OMI's mission, OMI has not defined these in measurable terms.[40] As a result, OMI is not able to systematically collect and analyze information to measure progress toward achieving pre-established goals in support of its mission.

In our prior work, we have reported that assessing progress toward meeting an entity's mission increases accountability and effectiveness. It helps managers ensure they are targeting efforts and resources at the highest priorities. Similarly, VHA policy states that program offices, such as OMI, are responsible for establishing performance measures and key indicators for performance as part of their program oversight responsibilities. According to VHA policy, such activities help support robust oversight and management of VHA activities.[41]

We have also reported that assessing progress toward meeting an entity's mission also helps managers clarify their work with respect to other entities doing similar work.[42] As one of several oversight offices within VHA, having performance information would help OMI and the other offices understand their respective roles as well as facilitate coordination across the offices.

OMI officials said it can be challenging to determine how to assess factors like timeliness because it is not as simple as setting a specific time frame for completing cases given their varying complexity. However, systematically collecting data on timeliness—through a performance measure—would help identify an average time and could be used in conjunction with other data to identify opportunities for improvement. For example, OMI officials said it could be beneficial to look at changes in

[40]OMI officials noted that the office established internal timelines for various steps in its investigative and report writing process, but it did not develop these for the purposes of setting performance goals and measures.

[41]Department of Veterans Affairs, *VHA Central Office Operating Units*.

[42]GAO/GGD-96-118; GAO-05-927.

average completion times in conjunction with changes in caseload. If the number of cases increased and the average time to complete cases also increased, this could indicate a need for additional resources.

Disaggregating and analyzing timeliness data by other factors, such as case characteristics, may also help identify more appropriate timeframes to complete those different types of cases. Officials also said they do not control their caseload or certain phases of the investigation and report processes, such as the time it takes to receive report concurrences from program offices required to concur on OMI reports. However, by setting goals that lay out clear priorities, OMI would be better positioned to make trade-off decisions and identify strategies to manage these types of challenges.

In addition, OMI officials said their current system of tracking information in spreadsheets is not conducive to easily collecting data in a standardized format and performing summary analyses across cases. For example, officials told us they have to manually pull case data to determine if they are taking too long to complete a particular process step, which they said is time intensive. Another example cited by officials is that they do not have the ability to easily generate a report that tells them which action plan items are currently open. However, OMI officials said they are in the early stages of researching options for a more effective data management system to collect and analyze information.

OMI officials said there were no specific obstacles or barriers that prevent them from taking the three performance management steps described above. However, they said it would be beneficial to have direction from the Under Secretary for Health when taking these steps to clarify the Under Secretary for Health's expectations for OMI.

Until OMI takes those key performance management steps, OMI may be limited in its ability to determine how well it is meeting its mission. By taking such steps, OMI would be better positioned to assess whether it needs to make any adjustments to its processes or resource allocation, or take other steps to improve its ability to meet its mission of monitoring and improving the quality of care provided to veterans. Moreover, performance information would allow VHA leadership to more fully understand and assess how OMI's work complements that of other oversight offices, helping to better ensure collective oversight and accountability across VHA's vast health care system.

Conclusions

OMI—one of several oversight offices within VHA—aims to improve the quality of veterans' care by making recommendations for corrective actions to address deficiencies identified through its investigations. Nearly all of OMI's cases have resulted in recommendations, with OMI reporting that the majority have been implemented. The adequacy of corrective actions is critical to ensuring the quality of care provided to veterans. However, OMI relies on one individual to make these key determinations. Adding a second level of supervisory review would help reduce risk and provide greater assurance that OMI's recommendations are implemented to fully address underlying concerns.

Moreover, it is important for OMI to have information on the extent to which it is meeting its vital mission. By taking key performance management steps, OMI would be better positioned to assess whether it needs to make any changes, such as adjustments to its processes or resource allocation or other changes. In addition, developing and using performance information would allow VHA leadership to more fully understand and assess how OMI's work complements that of other VHA oversight offices—especially as VHA undertakes the reorganization of its oversight functions—thereby helping to ensure the quality of health care services provided to veterans across VHA's vast health care system.

Recommendations for Executive Action

We are making the following four recommendations to VHA:

The Medical Inspector should establish and document responsibilities for supervisory review as a part of OMI's process for determining (1) whether proposed action plans address the intent of OMI's recommendations, and (2) whether action plans have been successfully completed. (Recommendation 1)

The VHA Under Secretary for Health should ensure that the Office of Medical Inspector establishes strategic goals and related performance goals. Such efforts should be in coordination with stakeholders, including the Under Secretary for Health and other VHA oversight offices. (Recommendation 2)

The VHA Under Secretary for Health should ensure that the Office of Medical Inspector establishes performance measures and collects relevant information to measure progress toward established performance goals. (Recommendation 3)

The VHA Under Secretary for Health should establish a process for regularly using performance information to assess progress toward

established goals and inform management decisions. (Recommendation 4)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix I, VA concurred with our recommendations.

Regarding our first recommendation, VA stated that OMI will update its standard operating procedure for action plans. In particular, OMI plans to specify that clinical program managers' decisions to accept proposed action plans and consider them complete will be reviewed and approved by OMI leadership.

Regarding our recommendations related to collecting and using performance information, VA outlined steps OMI plans to take to develop a strategic plan and associated performance goals. VA further stated that it is confident OMI is meeting its mission, but will develop performance information to better assess progress and areas for improvement. VA also provided one technical comment, which we incorporated.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or hundrupa@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Alyssa M. Hundrup
Director, Health Care

List of Requesters

The Honorable Jon Tester
Chairman
The Honorable Jerry Moran
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Mike Bost
Chairman
The Honorable Mark Takano
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Julia Brownley
Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Jack Bergman
House of Representatives

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

July 13, 2023

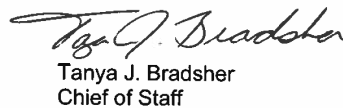
Ms. Alyssa M. Hundrup
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Hundrup:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA HEALTH CARE: Office of the Medical Inspector Should Strengthen Oversight of Recommendations and Assess Performance*** (GAO-23-105634).

The enclosure contains the action plan to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,



Tanya J. Bradsher
Chief of Staff

Enclosure

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The Department of Veterans Affairs Comments to
Government Accountability Office (GAO) Draft Report
VA HEALTH CARE: Office of the Medical Inspector Should Strengthen Oversight of Recommendations and Assess Performance
(GAO-23-105634)

Recommendation 1: The Medical Inspector should establish and document responsibilities for supervisory review as part of OMI's process for determining (1) whether proposed action plans address the intent of OMI's recommendations, and (2) whether action plans have been successfully completed.

VA Response: Concur. As discussed during this engagement and included in the Statement of Facts, the Medical Inspector submits a package to the Under Secretary for Health (USH), indicating that all aspects of an investigation have been completed and recommending USH closes the case. Prior to submission to USH, the Medical Inspector reviews all documents in the package including the action plan and its supporting documents to ensure that all actions have been completed as required. Once the Medical Inspector reviews this information and is confident all has been completed, the package is then submitted to USH for consideration for closure. This is detailed in Veterans Health Administration (VHA) Directive 1038, Role of the Office of the Medical Inspector dated January 30, 2023:

> *The Medical Inspector is responsible for submitting a closure package to the Under Secretary for Health when VA medical facilities or VA or VHA program offices have completed all action items in their Action Plans in response to report recommendations. NOTE: In the case of an OSC investigation, this package is prepared after OSC notifies the Executive Secretary, VA Office of the Secretary that an investigation is closed. The closure package consists of:*
>
> > *(a) A transmittal document recommending closure of the investigations; and*
> > *(b) An acceptance memorandum from the Under Secretary for Health to the Assistant Under Secretary for Health for Operations.*

However, for further clarification, the Office of the Medical Inspector (OMI) will add the following language to the OMI Action Plans Standard Operating Procedure:

The OMI Clinical Program Manager (CPM) will:

a) Determine if the proposed action(s) meet the intent of the recommendations and are sustainable.

   - Once determined the proposed actions meet the intent of the recommendations and are sustainable, send action plan to OMI leadership (the Medical Inspector (MI), Chief Senior Medical Investigator (SMI), Chief CPM and Executive Assistant (EA)) for review and approval.

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b) Notify the entity responsible for completing the recommendation (e.g., VA Program Office, VHA Program Office, Veterans Integrated Services Networks (VISN), VA health care facility) once their action plan has been approved;
c) Follow the action plan through implementation until completed; and
d) Provide OMI Leadership with action plan recommendation(s) and supporting documentation prior to closing action plan.

OMI Leadership (MI, Chief SMI, Chief CPM and EA) will:

a) Review the proposed actions and determine if these actions meet the intent of the recommendation and the actions are sustainable.

- If leadership determines that the proposed action items meet the intent of the recommendation(s) and are sustainable, OMI leadership will note the action plan as "approved" in the subject line of an email to the CPM(s).
- If leadership determines that the proposed action items do not meet the intent of the recommendation(s) or are not sustainable, OMI leadership will return the action plan to the CPM(s), noting the plan is "not approved" in the subject line of an email to the CPM(s) and indicating what additional information is needed.
- If leadership determines the completed recommendation(s) and supporting documentation provided by the CPM meet the intent of the recommendation(s), leadership will approve closure and will return the action plan to the CPM(s), noting the recommendation for "closure is approved" in the subject line of an email to the CPM(s).
- If leadership determines the completed recommendation(s) and supporting documentation provided by the CPM does not meet the intent of the recommendation(s), leadership will not approve for closure and return the action plan to the CPM(s), noting the recommendation for "closure is not approved," and indicating what additional information is needed.

Upon approval of Leadership to close action plan, the CPM will notify the entity responsible for completing the recommendation(s) (e.g., VA Program Office, VHA Program Office, VISNs, VA health care facility) the action plan has been closed.

Target Completion Date: December 2023

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Recommendation 2: The VHA Under Secretary for Health should ensure that the Office of Medical Inspector establishes strategic goals and related performance goals. Such efforts should be in coordination with stakeholders, including the Under Secretary for Health and other VHA oversight offices.

VA Response: Concur. In collaboration with USH and other VHA offices with oversight of OMI, OMI will undertake the following 10 steps in drafting a strategic plan:

1. Define mission and vision;
2. Conduct a comprehensive assessment;
   a. Strengths;
   b. Weaknesses;
   c. Opportunities; and
   d. Threats.
3. Forecast;
4. Set the organizational direction of OMI;
5. Create strategic objectives;
6. Coordinate with USH and other VHA offices with oversight of OMI to address fully GAO's recommendation;
7. Begin strategy mapping;
8. Determine strategic goals;
9. Determine performance goals; and
10. Conduct performance evaluation by USH of strategic and performance goals to determine whether:
    a. The goals measure activities and progress toward objectives; and
    b. The goals allow for the creation of improved plans and objectives to improve overall performance.

Target Completion Date: December 2023

Recommendation 3: The VHA Under Secretary for Health should ensure that the Office of Medical Inspector establishes performance measures and collects relevant information to measure progress toward established performance goals.

VA Response: Concur. Upon USH's approval of strategic and performance goals as outlined in Recommendation 2, OMI will develop specific performance measures and collect relevant data and information to assess progress towards meeting those goals.

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Recommendation 4: The VHA Under Secretary for Health should establish a process for regularly using performance information to assess progress toward established goals and inform management decisions.

VA Response: Concur. On a semi-annual basis OMI will provide USH with performance measure data and information with a request for review, assessment and recommendations.

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General Comment:

VHA OMI notes throughout the report that GAO references that OMI has not assessed its overall progress towards meeting its mission generally, and more specifically by not taking three key performance steps. Although OMI is confident it is meeting its mission, it will implement the items noted in the above action plan to better assess our progress and areas for improvement.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Hernán Bozzolo, Assistant Director; Michelle Paluga, Analyst-in-Charge; Barbara Hansen, Lisa Lusk, and Linda McIver made key contributions to this report. Also contributing were Jackie Hamilton, Ying Hu, Benjamin T. Licht, and Ethiene Salgado-Rodriquez.

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