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April 10, 2019

The Honorable John Boozman
Chairman
The Honorable Brian Schatz
Ranking Member
Subcommittee on Military Construction, Veterans' Affairs,
  and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Debbie Wasserman Schultz
Chairman
The Honorable John R. Carter
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
  and Related Agencies
Committee on Appropriations
House of Representatives

VA Management Challenges: Actions Needed to Improve Management and Oversight of VA Operations

The Department of Veterans Affairs (VA) is responsible for providing benefits to veterans, including health care to over 9 million enrolled veterans, as well as various types of financial assistance and burial services. However, VA has faced longstanding challenges managing and overseeing its operations. Given the challenges that we and others have documented with VA's ability to provide timely care to the nation's veterans, we added VA health care to the GAO High-Risk List in 2015.[1] This area joined several other government-wide high-risk areas that have direct implications for VA and its operations, including strategic human capital management, improving and modernizing federal disability programs, and ensuring the cybersecurity of the nation. In our March 2019 High-Risk report, we stated that we continue to be concerned about VA's ability to ensure that its resources are being used effectively and efficiently to improve veterans' access to high quality and safe health care.[2] We also added VA's acquisition management to the High-Risk List in March 2019. VA's continued vigilance in these areas is needed.[3]

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[1]Every 2 years at the start of a new Congress, GAO calls attention to agencies and program areas that are high risk due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or are most in need of transformation.

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

[3]For a full discussion of the Managing Risks and Improving VA Health Care; VA Acquisition Management; Strategic Human Capital Management; Improving and Modernizing Federal Disability Programs; and Ensuring the Cybersecurity of the Nation high risk areas, see pages 275 to 282, 210 to 216, 75 to 77, 259 to 266, and 178 to 184, respectively, of our 2019 high risk report, GAO-19-157SP.

Over the past several decades, we have issued hundreds of reports containing recommendations for VA to improve its management and oversight of the services it provides to veterans. As of January 9, 2019, VA had 223 open recommendations. Addressing these recommendations alone will not fully satisfy our high-risk concerns, as our recommendations are symptomatic of larger, systemic management and oversight challenges that VA must address. Nonetheless, fully implementing these open recommendations could significantly improve VA's operations. To this end, we began issuing letters to VA in 2017 identifying open recommendations that we consider to be the highest priority (i.e. priority recommendations) for VA to implement in order to significantly improve VA operations.[4]

The Committee report to the Consolidated Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2018 required GAO to submit a list of the most significant VA management issues on which GAO has made recommendations.[5] This report summarizes our priority open recommendations to address VA management and oversight challenges and improve operations, whether VA agreed with the recommendations, and what actions VA still needs to take to implement these recommendations. To address our objective, we reviewed GAO products with open recommendations to identify recommendations that may significantly improve VA operations in the following ways: (1) realizing large dollar savings; (2) aiding in congressional decision-making on major issues; (3) substantially improving major government programs; (4) eliminating mismanagement, fraud, and abuse; (5) ensuring that programs comply with laws and funds are legally spent; and (6) making progress toward addressing a high-risk or duplication, overlap, or fragmentation issue. This is also the same criteria that we used to identify recommendations for the VA priority open recommendation letters.

We conducted our work from October 2018 to March 2019 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

In summary, as of March 2019, VA had 30 priority open recommendations made by GAO that if implemented could significantly improve VA operations. These recommendations are in the areas of veterans' access to timely health care, veterans' use of community-based health care, quality of care and patient safety, information technology, and national policy reform, among others. For a complete list of VA's priority open recommendations, as well as a summary of the actions that VA needs to take to close each recommendation, see the enclosure.

We are sending copies of this report to the appropriate congressional committees and the Secretary of Veterans Affairs. In addition, the report is available at no charge on the GAO website at http://www.gao.gov. If you or your staffs have any questions on this report, please contact me at (202) 512-7114 or clowersa@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. Key

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[4]Priority 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. See GAO, *Priority Recommendations: Department of Veterans Affairs*, GAO-19-358SP (Washington, D.C.: Mar. 28, 2019).

[5]See H.R. Rep. No. 115-188, at 74 (2017).

contributors to this report were Marcia A. Mann (Assistant Director), Katie McConnell (Analyst-in-Charge), and Pamela Dooley.

A. Nicole Clowers
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Enclosure

Enclosure: Priority Open Recommendations to the Department of Veterans Affairs

Improving Oversight of Veterans' Access to Timely Health Care

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 Veterans Affairs (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 capture the application date for all newly enrolled veterans, which VA has indicated it intends to do by December 2019.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Debra A. Draper, Health Care

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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 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.

Recommendation: To better facilitate timely medical appointment scheduling and improve the efficiency and oversight of the scheduling process, we recommend that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VA medical centers (VAMC) consistently and accurately implement the Veterans Health Administration's (VHA) scheduling policy, including use of the electronic wait list, as well as ensuring that all staff with access to the VistA scheduling system complete the required training.

Actions Needed: VA agreed with both of our recommendations. To fully implement these recommendations, VA needs to provide documentation of completed training for all staff authorized to schedule appointments, including a national reconciliation of the list of staff who schedule appointments against the number of staff that have completed scheduling training. VA has reported that it plans to complete this reconciliation or have an action plan in place in March 2019. Overall, VA must demonstrate—and provide supporting evidence—that the scheduling policy and wait time measures ensure accurate and reliable measurement and reporting of veterans' appointment wait times, and improve the efficiency and oversight of the scheduling process.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Debra A. Draper, Health Care

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VA Health Care: Opportunities Exist for Improving Implementation and Oversight of Enrollment Processes for Veterans. GAO-17-709. Washington, D.C.: September 5, 2017.

Recommendation: The Secretary of VA should direct the Acting Under Secretary for Health to develop and disseminate a system-wide standard operating procedure that clearly defines the roles and responsibilities of VAMCs in resolving pending enrollment applications.

Recommendation: The Secretary of Veterans Affairs should direct the Acting Under Secretary for Health to clearly define oversight roles and responsibilities for the Health Eligibility Center (HEC), and for Veterans Integrated Service Networks (VISN), as appropriate, to help ensure timely processing of applications and accurate enrollment determinations.

Actions Needed: VA agreed with our recommendations. To fully implement these recommendations, VA needs to finish updating its policy that establishes requirements for processing enrollment applications. VA's policy needs to identify specific key performance indicators to be used to assess whether enrollment accuracy and timeliness standards are being met, and provide us documentation of these indicators. In addition, VA needs to provide documentation of the roles of HEC and VISNs in overseeing VAMCs' performance relative to the standards. VA also needs to provide us with documentation that clarifies what role VAMCs will have, if any, in resolving pending enrollment applications.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Debra A. Draper, Health Care

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Improving Oversight of Veterans' Community Care Program

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 VAMCs, 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.

Actions 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 otherwise 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

Acting Director: Sharon M. Silas, Health Care

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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

Acting Director: Sharon M. Silas, Health Care

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Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers. GAO-16-353. Washington, D.C.: May 11, 2016.

Recommendation: To help provide reasonable assurance that VHA achieves its long-term goal of modernizing its claims processing system, the Secretary of VA should direct the Under Secretary for Health to ensure that the agency develops a sound written plan that includes the following elements: (1) a detailed schedule for when VHA intends to complete development and implementation of each major aspect of its new claims processing system; (2) the estimated

costs for implementing each major aspect of the system; and (3) the performance goals, measures, and interim milestones that VHA will use to evaluate progress, hold staff accountable for achieving desired results, and report to stakeholders the agency's progress in modernizing its claims processing system.

Action Needed: VA agreed with our recommendation. VHA's Office of Community Care is consolidating VA's community care programs, and as part of this process it plans to transition to a third party administrator for the purposes of claims processing. While an active procurement is underway, VHA still needs to develop a written plan to fully implement this recommendation. VHA's written plan must include details about the schedule, cost estimates, performance goals, and interim milestones associated with transitioning to a third party administrator for the purposes of processing claims for VA community care.

High Risk Area: Managing Risks and Improving VA Health Care

Acting Director: Sharon M. Silas, Health Care

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Improving Management of Human Capital

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.

Recommendation: The Under Secretary for Health should conduct a comprehensive, system-wide evaluation of the physician recruitment and retention strategies used by VAMCs to determine their overall effectiveness, identify and implement improvements, ensure coordination across VHA offices, and establish an ongoing monitoring process.

Actions Needed: VA disagreed with the first 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 first 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. VA agreed with the second recommendation. According to VHA, the agency started a review of physician recruitment, retention, and relocation incentives in October 2017 that will include recommendations for a systematic approach to allocating workforce management resources, such as the Education Debt Reduction Program. Once completed, VHA will need to provide documentation of the review and its plans to monitor the implementation of any recommendations that will come out of the review to fully implement the second recommendation.

High Risk Area: Managing Risks and Improving VA Health Care, Strategic Human Capital Management

Director: Debra A. Draper, Health Care

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VA Health Care: Oversight Improvements Needed for Nurse Recruitment and Retention Initiatives. GAO-15-794. Washington, D.C.: September 30, 2015.

Recommendation: To help ensure the effective recruitment and retention of nurses across VAMCs, the Secretary of VA should direct the Under Secretary for Health to conduct a system-wide evaluation of VHA's key nurse recruitment and retention initiatives to determine the overall effectiveness of these initiatives, including any needed improvements, and communicate results and information in a timely manner to relevant stakeholders.

Action Needed: VA agreed with our recommendation and reported to us that VHA efforts continue to be ongoing to address this recommendation. To fully implement this recommendation, VHA will need to provide documentation that VHA has conducted a system-wide evaluation of its key nurse recruitment and retention initiatives. This documentation should describe needed improvements, how these efforts as a whole help VHA meet its overall nurse recruitment and retention goals, and how this information has been communicated to relevant stakeholders.

High Risk Area: Managing Risks and Improving VA Health Care, Strategic Human Capital Management

Director: Debra A. Draper, Health Care

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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.

Actions Needed: VA partially agreed with our recommendation, but has made limited overall progress in ensuring that meaningful distinctions are being made in employee performance ratings. To implement our recommendation, VA must (1) identify and implement procedures to better support ongoing and effective performance conversations between supervisors and employees; (2) review and revise performance management policies consistent with leading human capital practices to ensure meaningful distinctions in employee performance; and (3)

standardize employee performance plan elements, standards, and metrics for common positions across the VHA.

High Risk Area: Managing Risks and Improving VA Health Care

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, ensure that ratings-based performance awards are administered in a manner that is consistent with leading practices and promotes improved employee performance.

Action Needed: VA partially agreed with our recommendation and as of December 2018 had taken steps to help ensure that ratings-based performance awards are administered in a manner that is consistent with leading practices and that promotes improved employee performance. To implement our recommendation, VA must ensure that new procedures for administering performance awards are fully implemented across VHA medical centers.

High Risk Area: Managing Risks and Improving VA Health Care

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 this recommendation and as of December 2018 had established a project team to identify business requirements, analyze alternatives for an employee performance management IT system, and develop an implementation plan. VA also provided us with a high-level national proposal for acquiring a new performance management IT system.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Robert Goldenkoff, Strategic Issues

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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. To fully implement this recommendation, VA must provide evidence of a 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. VA's target date for system implementation is January 2020.

High Risk Area: Managing Risks and Improving VA Health Care

Recommendation: The Secretary of VA should ensure that employees who report wrongdoing are treated fairly and protected against retaliation.

Actions Needed: VA agreed with our recommendation. To fully implement this recommendation, VA needs to provide evidence of actions taken to ensure that whistleblower protections included in law are implemented. Such actions include (1) establishing guidance for implementation of the law; (2) delegating authority to implement the law; and (3) hiring additional staff to increase awareness of whistleblower protections and assist individual disclosing employees.

High Risk Area: Managing Risks and Improving VA Health Care

Director: Kathy Larin, Forensic Audits and Investigative Service

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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 subsequently provided us with expected completion dates for implementation of claims and appeals processing. To fully implement this recommendation, the department needs to provide a schedule of the activities necessary to achieve these completion dates, and estimate the cost to complete development and implementation of VBMS.

High Risk Area: Improving the Management of IT Acquisitions and Operations

Director: Carol C. Harris, Information Technology Acquisition Management Issues

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Data Center Consolidation: Agencies Making Progress, but Planned Savings Goals Need to Be Established. GAO-16-323. Washington, D.C.: March 3, 2016.

Recommendation: The Secretary of VA should take action to improve progress in the data center optimization areas that we reported as not meeting the Office of Management and Budget's (OMB) established targets, including addressing any identified challenges.

Action Needed: VA agreed with our recommendation. While OMB no longer requires reporting on seven of the nine metrics against which VA was originally assessed, progress against the remaining two metrics is needed to fully implement this recommendation. It is important that VA

accurately report data center optimization progress to OMB and improve departmental progress against meeting these metrics to ensure that OMB and Congress have the ability to oversee VA's progress against key data center optimization goals.

High Risk Area: Improving the Management of IT Acquisitions and Operations

Director: Carol C. Harris, Information Technology Acquisition Management Issues

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<u>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.</u>

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. To fully implement this recommendation, VA needs to document the role and responsibilities of the Interagency Program Office with respect to VA's acquisition of its new electronic health record system, explaining the role, if any, the Interagency 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 Acquisition Management Issues

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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.

Actions 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.

Actions Needed: VA agreed with our recommendation. To fully implement our recommendation, VA will need to assess risk against a balanced set of goals, articulate success criteria for assessing results of pilot tests for the new process (e.g., "RAMP"), and test or conduct sensitivity analyses of all appeal options before proceeding to full implementation.

High Risk Area: Improving and Modernizing Federal Disability Programs

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

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Improving Oversight to Ensure Safe, High Quality Care for Veterans

VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns. GAO-18-63. Washington, D.C.: November 15, 2017.

Recommendation: The Under Secretary for Health should require VISN officials to oversee VAMC reviews of providers' clinical care after concerns have been raised, including retrospective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool. This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner.

Recommendation: The Under Secretary for Health should require VISN officials to establish a process for overseeing VAMCs to ensure that they are reporting providers to the National Practitioner Data Bank (NPDB) and state licensing boards (SLB), and are reporting in a timely manner.

Actions Needed: VA agreed with our recommendations. To fully implement these recommendations, VHA needs to complete revisions to the standardized audit tool so that it directs the VISNs to (1) oversee reviews of providers' clinical care after concerns have been raised; and (2) ensure timely reporting to the NPDB and SLBs, in accordance with VHA policy. VHA also needs to implement the VISN-level oversight of all 170 VAMCs using the revised tool, review the aggregate results, and take corrective actions where deficiencies, trends, or issues are identified. This would include demonstrating that the providers we identified in our review have been reported to the NPDB and SLBs.

High Risk Area: Managing Risks and Improving VA Health Care

Acting Director: Sharon M. Silas, Health Care

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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.

Actions Needed: VA agreed with our recommendation. To fully implement this recommendation, VHA needs to ensure, as required by VHA policy, that all 18 VISNs have an academic detailing program established that regularly provides education and support to all VHA medical facilities located in the VISN. Also, all VHA medical facilities should have a designated primary care pain champion who is knowledgeable about pain care, and can serve as a resource for other primary care providers by promoting safe and effective pain care. VA reported that it plans to complete both of these actions by April 2019.

High Risk Area: Managing Risks and Improving VA Health Care

Managing Director: A. Nicole Clowers, 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.

Actions 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 (recertified VHA Directive 6330), which should clarify the use of national policy and guidance documents, as well as their recertification requirements. For guidance documents, this should include the use, vetting, and recertification of all types of memos, including, but not limited to, 10N memos. VA reported that it plans to complete these actions by June 2019.

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. VA's contracting workforce has been relying on an outdated 2008 version of the Veterans Affairs Acquisition Regulation.

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 (MSPV-NG) 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.

Actions Needed: VA agreed with our recommendation. In February 2019, VA developed a new, overarching acquisition strategy for its MSPV program, and has begun the process of communicating it to key stakeholders. To fully implement this recommendation, VA needs to provide documentation on the extent to which clinicians are involved in prioritizing categories of supplies for future phases of requirement development and contracting.

High Risk Area: VA Acquisition Management

Director: Shelby Oakley, Contracting and National Security Acquisitions

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Improving Management of VA's National Cemetery Program

> Veterans Affairs: Data Needed to Help Improve Decisions Concerning Veterans' Access to Burial Options. GAO-14-537. Washington, D.C.: September 9, 2014.

Recommendation: To better enable VA's National Cemetery Administration (NCA) to meet its mission of providing reasonable access to burial options at veterans' cemeteries, the Secretary of VA should direct the Under Secretary for Memorial Affairs to use the capability of NCA's existing software to estimate the served and unserved veteran populations using census tract data.

Actions Needed: VA disagreed with our recommendation. Although VA agreed that census tract data was more precise than the county-level data NCA was using, the department disagreed that using this more precise data to make decisions would lead to different outcomes. Instead, VA believed that NCA's methodology of using county-level data was sufficient for estimating the number of served and unserved veterans. We disagree and are skeptical of VA's assertion that using more precise data to identify served and unserved veterans would have no effect on the outcome of VA's decisions about cemetery locations or prioritization. Therefore, we maintain that our recommendation is still valid. To fully implement this recommendation, VA must provide evidence that it is using census tract data with its own mapping software to analyze the number of veterans served.

Director: Diana Maurer, Defense Capabilities and Management

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