United States Government Accountability Office

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Wednesday, October 27, 2021

VETERANS HEALTH CARE

Addressing High Risk Concerns for Oversight and Accountability Are Key to Ensuring Quality of Care and Patient Safety

Statement of Sharon M. Silas, Director, Health Care

Accessible Version

GAO@100
A Century of Non-Partisan Fact-Based Work

GAO-22-105474

GAO Highlights

Highlights of GAO-22-105474, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

October 27, 2021

VETERANS HEALTH CARE

Addressing High Risk Concerns for Oversight and Accountability Are Key to Ensuring Quality of Care and Patient Safety

Why GAO Did This Study

VA operates one of the nation's largest health care systems. GAO's work, along with that of VA's Office of Inspector General and others, has cited longstanding issues with VA's oversight of its health care system.

In 2015, GAO added VA health care to its High-Risk List, in which one broad area of concern was inadequate oversight and accountability. In its latest high-risk update in March 2021, GAO noted continued concern over VA's ability to ensure the safety and protection of patients and staff, as well as to oversee its programs.

This statement describes the oversight and accountability issues GAO's work has identified related to quality care and patient safety, and the status of VA's efforts to address its high-risk designation. This statement is based on GAO's body of work in this area.

GAO's Fiscal Year 2021 Rating for the Inadequate Oversight and Accountability Area

Source: GAO. | GAO-22-105474

View GAO-22-105474. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

What GAO Found

GAO's work has identified a range of concerns with the Department of Veterans Affairs' (VA) oversight and accountability of its health care system, including those related to quality of care and patient safety. Since GAO added VA health care to its High-Risk List in 2015, GAO has made 131 recommendations related to VA's oversight and accountability, almost half of all GAO's recommendations for VA health care. Recent examples of quality of care and patient safety recommendations include the following:

- VA has faced challenges in ensuring that its providers deliver safe and effective care to veterans. In February 2021, GAO identified 227 providers that had been removed from VA employment but were potentially providing care in a community care network. GAO recommended that VA take actions to assess and address the situation. VA implemented this recommendation by reviewing and excluding 155 providers from participating in VA's community care networks.
- In recent years, there have been reports of veterans dying by suicide on VA campuses—in locations such as inpatient settings, parking lots, and on the grounds of VA cemeteries. In September 2020, GAO found that VA lacks accurate information on the number of suicides and comprehensive analyses of the underlying causes. While VA agreed with two of GAO's recommendations to address these issues, VA still needs to provide documentation of key actions taken by the committee it established to improve its understanding of on-campus suicides.
- In June 2019, GAO found that VA's oversight of its regional health care networks was limited. GAO recommended that VA develop a process for assessing the overall performance of its networks to be able to better determine if a network's performance is positive, if it is functioning poorly, or if it requires remediation. While VA concurred with GAO's recommendation, VA still needs to provide documentation of the process developed to assess the overall performance of these networks in managing medical centers.

Since the last high-risk update in March 2021, VA has taken steps to address some of the oversight and accountability concerns identified by GAO. In May 2021, VA published a revised high-risk action plan for addressing VA health care concerns. However, VA is still in the beginning stages of developing its plan to address root causes such as a fragmented oversight and accountability infrastructure and will need clearly defined metrics to ensure it is effective. Fully addressing oversight and accountability concerns also requires sustained leadership attention as well as leadership stability. However, the Under Secretary for Health position responsible for managing VA health care has not had permanent leadership since January 2017. While VA takes steps to address its needed transformation, it should continue to implement recommendations GAO has made in the oversight and accountability area, given the number of these similar types of recommendations and the need to ensure quality of care and patient safety.

Chairwoman Brownley, Ranking Member Bergman, and Members of the Subcommittee:

Thank you for the opportunity to discuss the oversight and accountability issues we have identified in our work on the Department of Veterans Affairs' (VA) health care system. VA operates one of the nation's largest health care systems, which comprises 171 VA medical centers and more than 1,000 outpatient facilities organized into 18 regional networks called Veterans Integrated Service Networks (VISN). 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.

Our work, along with that of VA's Office of Inspector General and others, has cited longstanding concerns about VA's oversight of its health care system. Specifically, there have been concerns about 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. For example, a series of infectious disease outbreaks at several VA facilities over a number of years—and allegations that VA officials may have withheld information about the outbreaks from the public—have previously raised concerns about the effectiveness of patient safety practices at its facilities. Congressional hearings in 2017 and 2019 also examined VA's failures to ensure a culture of safety in its facilities. These hearings highlighted the lack of VA oversight to ensure that its providers have the appropriate qualifications and clinical abilities to deliver high quality, safe care to veterans, or that providers' records are reviewed when concerns about their clinical care are raised.

In 2015, GAO added VA health care to GAO's High-Risk List.[1] This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation. To determine which federal government programs and functions should be designated "high risk," we consider factors such as whether the risk involves public health or safety.[2] For VA, there are risks to the safety, quality, timeliness, and cost-effectiveness of veterans' health care. We

[1]See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[2]See GAO, *Determining Performance and Accountability Challenges and High Risks*, GAO-01-159SP (Washington, D.C.: Nov. 1, 2000).

have identified persistent weaknesses with VA's management and oversight of its health care system, making numerous recommendations that aim to address them.[3] In designating VA health care as high-risk, we categorized our concerns into five broad areas, including inadequate oversight and accountability.[4] As of October 2021, oversight and accountability issues have comprised close to half of our 275 recommendations for VA health care since we designated this area as high risk.[5]

You asked us to testify today due to continuing organization-wide oversight and accountability concerns at VA. My remarks focus on

1. the oversight and accountability issues our work has identified related to quality care and patient safety; and
2. the status of VA's efforts to address its high-risk designation in the area of oversight and accountability.

This statement is based on our body of work addressing oversight and accountability issues in VA health care, including recommendations related to quality of care or patient safety concerns. More detailed information on the objectives, scope, and methodology of this work can be found in each issued report. This statement is also based on our review of VA's efforts to address its high-risk designation since our March 2021 High-Risk report, such as information VA has made publicly available. We conducted the work on which this statement is based 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

[3]We have also reported since 2000 about VA facilities' failure to provide timely health care. In some cases, these delays (or VA's failure to provide care at all) have reportedly harmed veterans. For example, there were several well-publicized events that raised concerns about wait times for appointments at VA medical facilities.

[4]The four other broad areas are ambiguous policies and inconsistent processes; information technology challenges; inadequate training for VA staff; and unclear resource needs and allocation priorities. See GAO-15-290.

[5]Of the remaining 144 VA health care recommendations, 26 percent were in the area of ambiguous policies and inconsistent processes, 11 percent were in the area of unclear resource needs and allocation priorities, 8 percent were in the area of information technology challenges, 7 percent were in the area of inadequate training for VA staff, and 1 percent were not related to a high-risk area of concern.

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

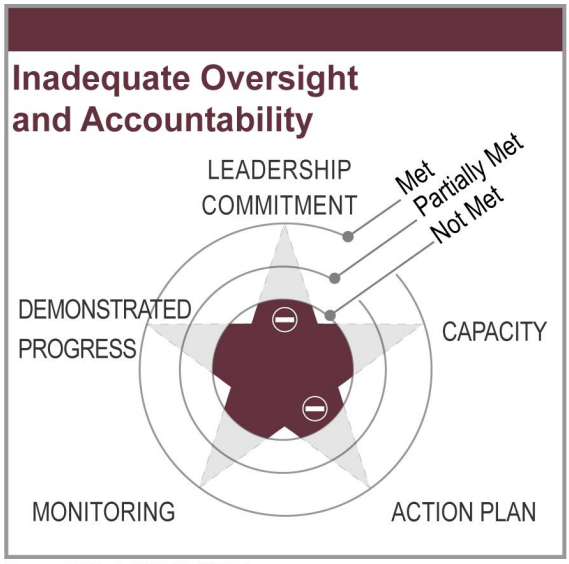
Background

The management of VA health care takes place at the Veterans Health Administration's central office, where the Under Secretary for Health provides leadership over numerous clinical programs and administrative offices, including those related to quality of care and patient safety. The central office level is generally responsible for setting program requirements and developing policies, and does not conduct oversight of program implementation at the local level. Instead, VA's health care delivery system is organized into 18 VISNs, each responsible for overseeing VA medical centers and other VA facilities within a defined geographic area. As part of their delivery of care, VA facilities perform specific activities related to investigating and reporting on quality of care and patient safety issues, such as adverse events.

In our March 2021 High-Risk Report, we noted continuing concerns about VA's ability to ensure the safety and protection of patients and staff, as well as to oversee its programs. At that time, for the area related to inadequate oversight and accountability concerns, the ratings for two criteria regressed and three remained unchanged since our 2019 High-Risk Report.[6] See figure 1.

[6]See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021). We rate high-risk areas' progress on five criteria for removal from the High-Risk List (leadership commitment, capacity, action plan, monitoring, and demonstrated progress). A "met" rating means that the agency has taken actions that meet the criterion and there are no significant actions that need to be taken to further address this criterion. A "partially met" rating means that the agency has taken some, but not all, actions necessary to meet the criterion. A "not met" rating means that the agency has taken few, if any, actions toward meeting the criterion.

Figure 1: GAO's Rating for the Inadequate Oversight and Accountability Area, as of the Fiscal Year 2021 High-Risk Report



Source: GAO. I GAO-22-105474

Note: In designating Department of Veterans Affairs (VA) health care as high-risk, we categorized our concerns into five broad areas, including inadequate oversight and accountability. We rate high-risk areas' progress on five criteria for removal from the High-Risk List (leadership commitment, capacity, action plan, monitoring, and demonstrated progress). A minus symbol inside the star indicates the rating for that criterion declined since our last update.

Along with these ratings, we described the status of VA's efforts to address oversight and accountability concerns for each of the High-Risk List criteria for removal (see table 1). In particular, we noted that VA should demonstrate commitment to oversight and accountability by ensuring its action plan, such as the one VA provided to us in October 2020, serves as a clear roadmap that identifies what needs to be done and how it will accomplish these activities.

Table 1: Department of Veterans Affairs (VA) Progress against Criteria for Removal of the Inadequate Oversight and Accountability Area of Concern from GAO's High-Risk List, as of the Fiscal Year 2021 High-Risk Report

High-risk criteria for removal	Description of criterion	GAO's rating in fiscal year 2021 High-Risk Report
Leadership commitment	Demonstrated strong commitment and top leadership support.	**Not met.** Since 2019, VA regressed in this criterion as the Under Secretary for Health position remained unfilled; instead, VA had an Executive-in-Charge leading its Veterans Health Administration, including its high-risk efforts and major modernization initiatives. Turnover among the senior executives leading VA's response to its high-risk designation that occurred after VA established root causes and outcomes for this area of concern made leadership commitment unclear.
Capacity	Agency has the capacity (i.e., people and resources) to resolve the risk(s).	**Not met.** VA had taken steps to establish initial compliance, internal audit, and risk management activities (central components of the agency's oversight and accountability model) prior to 2019. However, VA's action plan indicated that it had made minimal progress since that time to further develop these activities, and VA did not clearly identify capacity needs for most outcomes in this area of concern.
Action plan	A corrective action plan exists that defines the root cause and solutions and provides for substantially completing corrective measures, including steps necessary to implement solutions we recommended.	**Not met.** Since 2019, VA regressed in this criterion as it did not go on to develop the key components of its action plan. Specifically, the action plan did not include thoroughly developed critical actions, milestones, or performance measures to reach its stated outcomes. For example, the action plan stated that governance at the Veterans Health Administration will ensure accountability with its requirements by the end of fiscal year 2020. However, the plan only included one critical action—that its high-risk workgroup identify and collaborate with relevant stakeholders. VA also did not establish any performance measures or metrics. As a result, it is unclear how VA intended to achieve this outcome.
Monitoring	A program has been instituted to monitor and independently validate the effectiveness and sustainability of corrective measures.	**Not met.** In its action plan, VA included a few monitoring activities for this area of concern, such as reviewing corrective actions. However, the action plan did not say who is responsible for these activities or how VA will track progress on them.
Demonstrated progress	Ability to demonstrate progress in implementing corrective measures and in resolving the high-risk area.	**Not met.** VA cannot show that it is addressing root causes due to the lack of details in its action plan. Our work has indicated that there are continuing oversight and accountability issues, and since 2019, we have made 30 recommendations to address these issues.

Source: GAO. | GAO-22-105474

Note: We rate high-risk areas' progress on five criteria for removal from the High-Risk List (leadership commitment, capacity, action plan, monitoring, and demonstrated progress). A "met" rating means that the agency has taken actions that meet the criterion and there are no significant actions that need to be taken to further address this criterion. A "partially met" rating means that the agency has taken some, but not all, actions necessary to meet the criterion. A "not met" rating means that the agency has taken few, if any, actions toward meeting the criterion.

Recommendations on VA Health Care Continue to Identify a Range of Oversight and Accountability Issues Affecting Quality of Care and Patient Safety

Our work on VA health care has continued to identify oversight and accountability issues. In particular, our work has identified various concerns related to the quality of care provided in the VA health care system. Broadly, quality of care is that which is safe, effective, patient-centered, timely, efficient, and equitable, according to a seminal Institute of Medicine report in 2001. However, we have found that VA's oversight of quality of care is lacking in a number of areas, some of which it has yet to address. For example:

- **Regional network oversight.** VA's regional health care networks (or VISNs) manage the day-to-day functions of VA medical centers and also provide administrative and clinical oversight of these medical centers. However, in June 2019, we reported that VA's oversight of VISNs was limited.[7] For example, VA had not established a process for assessing the overall performance of VISNs in managing and overseeing medical centers. We recommended that VA develop such a process to be able to better determine if a VISN's performance is positive, if it is functioning poorly, or if it requires remediation. VA concurred with our recommendation and noted its ongoing efforts to define management and governance roles and responsibilities. To fully implement this recommendation, VA will need to provide evidence of the process, including any metrics or tools, developed to assess the overall performance of VISNs in managing medical centers.
- **Provider qualifications.** VA has faced challenges in ensuring that its health care providers deliver safe and effective care to veterans. We have previously identified situations where providers who were removed from employment by VA medical facilities for quality of care concerns went on to provide care outside VA and to enroll in VA's

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

community care networks, allowing them to continue to care for veterans.[8]

In February 2021, for example, we identified 227 providers that had been removed from VA employment and were potentially providing care to veterans and other patients in a community care network.[9] As a result, we recommended that VA take actions to assess and address the situation. VA implemented our recommendation by reviewing the 227 providers we identified and subsequently excluding 155 providers from providing care through the VA's community care networks and allowing 72 providers to continue participating. Of the 155 excluded providers, VA found 141 whom were not eligible to participate in VA's community care networks based on program requirements and 14 whom had been previously terminated from VA for adverse employment actions and therefore were not eligible to participate in VA's community care networks.[10]

- **Patient advocacy.** VA has designated patient advocates at each VA medical center to receive and document feedback—including requests for information, compliments, and complaints—from veterans or their representatives. Reviewing data from patient advocates that

[8]We previously reported on the implementation and oversight of VA processes for reviewing and reporting quality and safety concerns about VA providers. See GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6 (Washington, D.C.: Feb. 28, 2019) and *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety* Concerns, GAO-18-63 (Washington, D.C.: Nov. 15, 2017).

[9]See GAO, *Veterans Community Care Program: Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded*, GAO-21-71 (Washington, D.C.: Feb. 1, 2021).

[10]Section 108 of the VA MISSION Act established requirements for VA to prevent certain providers from delivering VA community care to veterans by defining criteria under which VA must deny, revoke, or suspend a provider's eligibility to provide care to veterans through VA's community care program. Specifically, providers are ineligible to participate in VA's community care program if they (1) have lost a state medical license in any state for violating the requirements of the medical license; (2) have been removed from employment with VA due to conduct that violated VA policy relating to the delivery of safe and appropriate health care; or (3) have been suspended from employment with VA. See Pub. L. No. 115-182, tit. I, § 108, 132 Stat. 1393, 1416-1417 (2018).

We also have ongoing work assessing VA's efforts to mitigate vulnerabilities in the controls it is using to ensure providers are appropriately credentialed and eligible to participate in VA's community care program.

includes codes related to patient safety can allow VA to identify potential system-wide issues that, if addressed, could significantly improve the experience of veterans. However, in April 2018, we reported that VA had not monitored patient advocacy program data-entry practices or reviewed the data to assess program performance.[11] As a result, VA faces a risk that not all complaints are entered into the program's tracking system and may miss opportunities to improve veterans' experiences. We recommended that VA monitor its data-entry practices for the patient advocacy program to ensure all complaints are entered and that veterans' feedback is coded consistently. VA has implemented our recommendation by (1) reviewing and standardizing codes across various data systems, (2) developing a tool to ensure standardized, timely documentation of complaints that includes accurate coding, and (3) piloting the tool to obtain feedback on its use and make necessary adjustments. After completing training and deployment steps, VA began monitoring patient advocacy program data-entry practices in July 2021.

Our work has also identified various concerns related to patient safety—the prevention of harm to patients—in the VA health care system.

- **Suicide prevention.** Preventing suicide is VA's highest clinical priority. In recent years, there have been reports of veterans dying by suicide on VA campuses—in locations such as inpatient settings, parking lots, and on the grounds of VA cemeteries. However, VA has not done enough to develop a full understanding of the prevalence and nature of on-campus suicides, hindering its ability to address them.[12]

  In September 2020, we reported that VA lacks accurate information on the number of suicides and comprehensive analyses of the underlying causes.[13] For example, VA does not make use of all relevant information it collects about these deaths, such as clinical and demographic data collected through other VA suicide prevention

[11]See GAO, *VA Health Care: Improved Guidance and Oversight Needed for the Patient Advocacy Program*, GAO-18-356 (Washington, D.C.: Apr. 12, 2018).

[12]We have ongoing work assessing VA's efforts to identify and manage veterans at high risk for suicide, including predictive models.

[13]See GAO, *Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664 (Washington, D.C.: Sept. 9, 2020).

efforts. We made three recommendations for VA to obtain accurate data and to complete comprehensive analyses to better understand on-campus suicides. VA agreed with two of our three recommendations and stated that it had established a committee that meets on a monthly basis to improve its understanding of on-campus suicides, such as by developing and finalizing processes for the coordination and review of on-campus suicide death data and analyses.[14] To fully implement these recommendations, VA will need to provide evidence of the processes the committee has put in place, including updated policy directives and completed analyses.

- **Infection prevention and control in long-term care facilities.** Thousands of veterans rely on nursing home care provided or paid for by VA to help them meet their skilled nursing and personal care needs. Many veterans receive this care in one of VA's 134 community living centers. Community living centers are owned and operated by VA and are associated with, and may be located in, on the campuses of, or near VA medical centers. Given the risk the Coronavirus Disease 2019 (COVID-19) pandemic poses in nursing homes, VA's management of the response for community living centers is of critical importance.[15]

  In July 2021, we found that VA conducted limited oversight of infection prevention and control in these facilities during the first year of the pandemic, from March 2020 through February 2021.[16] For example, VA required that community living centers conduct a one-time self-assessment of their infection prevention and control practices but did not review the results in a timely manner to make more immediate improvements. We recommended that VA conduct a retrospective assessment of its oversight of infection prevention and control in community living centers during the COVID-19 pandemic to identify lessons learned and be better prepared for future infectious disease outbreaks. VA concurred with our recommendation in principle. VA stated that, by January 2022, it will review the results of the community living centers' assessments of their infection prevention

[14]VA did not concur with our recommendation related to conducting root cause analyses. We continue to believe that this recommendation is valid, as discussed in the report.

[15]We have ongoing work examining data trends on the quality of care in VA's community living centers, as well as ongoing work assessing how VA receives, investigates, and resolves complaints about care at its community living centers. We will also examine how VA uses data and complaints information in the oversight of community living centers to improve care.

[16]See GAO, *COVID-19: VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers*, GAO-21-559 (Washington, D.C.: July 28, 2021).

and control practices and require them to take any needed corrective actions.

As of October 2021, VA had implemented 81 percent (154 of 190) of VA health care recommendations related to oversight and accountability we have made since January 2010. However, VA has not yet fully implemented 19 percent (36 of 190) of these recommendations that could further ensure that quality of care and patient safety concerns are adequately addressed. Specifically, VA has not fully implemented 31 recommendations related to an aspect of quality of care, eight of which are related to patient safety. Some of these 36 recommendations are also included in a letter we send each year to the Secretary of VA that details open recommendations that we deem the highest priority for implementation.[17] For example, one priority recommendation is our September 2020 recommendation for VA to obtain more accurate information on the number of on-campus suicides.

Fully addressing open recommendations related to VA's oversight and accountability could significantly improve VA operations. However, as we reported when we added VA health care to the High-Risk List, the number of recommendations to address similar types of oversight and accountability issues—such as quality care and patient safety—are symptomatic of the need for broader, systemic management and an oversight challenge that can only be addressed through transformative action. Key to making this needed transformation is having an action plan that identifies the root causes of oversight and accountability issues, such as VA's fragmented oversight and accountability infrastructure, and that clearly details what needs to be done and how VA will accomplish these activities.

[17]See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, GAO-21-469PR (Washington, D.C.: May 10, 2021). 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.

Despite VA's Efforts, Oversight and Accountability Remain an Area of High Risk

VA has taken steps to address its high-risk designation in the area of oversight and accountability. These steps have included the following:

Reorganizing its Veterans Health Administration Central Office in January 2020. As part of its ongoing modernization initiatives, VA undertook an effort to reorganize its central office structure at the Veterans Health Administration. This effort realigned oversight functions at the Veterans Health Administration into a single office that directly reports to its top leadership, the Under Secretary for Health. Prior to the reorganization, these oversight functions were separately located in offices dedicated to integrity, risk management, and internal audit. VA stated that the goal of the realignment was to clarify office roles, streamline responsibilities, and improve coordination across program offices in the Veterans Health Administration. As this reorganized office expands to address oversight and accountability needs at the Veterans Health Administration, it is important that there is a clearly defined entity at the Veterans Health Administration responsible for key oversight responsibilities, such as risk management activities.

Revising its high-risk action plan in May 2021. The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, enacted in January 2021, required VA to submit to Congress a plan addressing high-risk areas designated by GAO, including VA health care.[18] In May 2021, VA published a revised version of its high-risk action plan for addressing VA health care concerns. In this version, VA made progress in developing a clear roadmap for addressing oversight and accountability concerns by further developing the critical actions and milestones to reach its stated outcomes, as well as more clearly identifying the capacity needs for these outcomes. For example, VA described the actions it is taking to deploy an integrated risk management process to program offices, VISNs, and facilities, starting with an environmental scan of existing risk management efforts conducted at each level of the organization. It also identified the resources needed to

[18]Pub. L. No. 116-315, § 7007, 134 Stat. 4932, 5059 (2021). The act also requires VA to provide annual updates on its progress, which provides an important oversight mechanism for VA's high-risk efforts. VA officials told us they are working on the next version of the action plan, which they plan to issue in the summer of 2022.

conduct this work, such as fully staffing the reorganized office responsible for all integrity, risk management, and internal audit functions.

We identified deficiencies in VA's May 2021 action plan, such as the need to make more progress on developing performance measures and metrics that clearly show how VA intends to achieve each outcome. Specifically, the metrics under one outcome describe actions VA will take, such as publishing a policy directive, instead of measuring progress. Under other outcomes, it is unclear how VA will use metrics, such as a metric related to holding quarterly meetings, to assess progress due to a lack of measurable data. For example, one of VA's oversight and accountability goals to becoming a high reliability organization is that its employees demonstrate a culture of safety and integrity.[19] However, these metrics are not yet sufficient to measure progress against VA's identified goal. Specifically, VA has one metric that measures employee perceptions of a patient safety culture and one metric it has not yet developed to assess its culture of integrity. VA is in the process of developing the next version of its action plan, which it intends to include updated metrics. These metrics should clearly show how VA intends to achieve each outcome in order to demonstrate progress on addressing oversight and accountability concerns.

In addition, the oversight and accountability infrastructure VA is developing, as described in its May 2021 action plan, is still in its beginning stages. VA anticipates that the infrastructure it is putting in place will take time to embed across the organization, starting this fiscal year and continuing over the next 3 years. Given the magnitude of change VA intends to make, this is a realistic time frame to conduct such work. However, VA will need clearly defined metrics to ensure the structures and processes it is putting in place during this time are effective.

Fully addressing oversight and accountability concerns will also require sustained leadership attention on these issues as well as leadership stability. Since its designation as a high-risk area in 2015, the Under Secretary for Health position responsible for managing VA health care has mostly been vacant and has not had permanent leadership since January 2017. It is critical that a senior leader with sufficient positional authority to drive organizational action is charged with addressing high-

[19]A high reliability organization is one that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results.

risk concerns, particularly for oversight and accountability of VA health care delivery.

In closing, VA is in need of transformation, which must include improvements in the oversight and accountability of its health care system. Safeguarding the quality and safety of health care services provided to veterans is essential and VA must demonstrate more progress in holding its health care facilities accountable and managing risk, including preventing adverse events and resolving identified problems in a timely and appropriate manner. While VA is developing its efforts to address oversight and accountability concerns, VA should continue to address the recommendations we have made in this area, particularly those that ensure quality of care and patient safety.

Chairwoman Brownley, Ranking Member Bergman, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Ann Tynan (Assistant Director) and E. Jane Whipple (Analyst-in-Charge). Other contributors include Laurie Chin, Jacquelyn Hamilton, Vikki Porter, Ethiene Salgado-Rodriguez, and Cathy Hamann Whitmore.

Related GAO Reports

COVID-19: VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers. GAO-21-559. (Washington, D.C.: July 28, 2021).

Priority Open Recommendations: Department of Veterans Affairs. GAO-21-469PR. (Washington, D.C.: May 10, 2021).

High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas. GAO-21-119SP. (Washington, D.C.: March 2, 2021).

Veterans Community Care Program: Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded. GAO-21-71. (Washington, D.C.: February 1, 2021).

Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides. GAO-20-664. (Washington, D.C.: September 9, 2020).

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

VA Health Care: Improved Guidance and Oversight Needed for the Patient Advocacy Program. GAO-18-356. (Washington, D.C.: April 12, 2018).

High-Risk Series: An Update. GAO-15-290. (Washington, D.C.: February 11, 2015).

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548