GAO@100 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.