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Washington, DC 20548

Comptroller General
of the United States

June 30, 2022

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Priority Open Recommendations: Department of Veterans Affairs

Dear Mr. Secretary:

The purpose of this letter is to provide an update on the overall status of the Department of Veterans Affairs' (VA) implementation of GAO's recommendations and to call your continued attention to recommendations that should be given high priority.¹ In November 2021, we reported that, on a government-wide basis, 76 percent of our recommendations made 4 years ago were implemented.² As of May 2022, VA's recommendation implementation rate was 87 percent for these recommendations, and VA had a total of 208 recommendations that had not been implemented. Implementing these recommendations could significantly improve agency operations.

Since our May 2021 letter, VA has implemented eight of our 28 open priority recommendations. Specifically, VA

- issued revisions to its outdated acquisitions regulations, which we recommended be expedited in September 2016;
- issued a recertified national policy directive that clarifies the use of policy and guidance documents at both national and local levels, as recommended in our September 2017 report;
- reported meeting the targets that the Office of Management and Budget established for data center optimization metrics, per our April 2019 recommendation;
- implemented a May 2019 recommendation to develop a plan with specific milestones and timeframes to move towards eliminating the use of knowledge-based verification in its online identity verification processes;

¹Priority 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.

²GAO, *Performance and Accountability Report: Fiscal Year 2021*, [GAO-22-4SP](#) (Washington, D.C.: Nov. 15, 2021).

- implemented two recommendations from a July 2019 report to establish a cybersecurity risk management strategy and a process for conducting organization-wide cybersecurity risk assessments;
- determined that the extent of duplication between the Federal Supply Schedule and the Medical Surgical Prime Vendor programs is appropriate, and is necessary to meet the goals of the two programs, in response to our recommendation from January 2020; and
- began publicly reporting, on its website, COVID-19 cases and deaths among residents and staff at each of the 158 state veterans homes, as recommended in our November 2020 report.

We ask for your continued attention to the remaining 20 recommendations. We are also adding two new recommendations related to using a balanced set of performance metrics to manage the department's procurement organizations and improving VA's ability to assess the performance of its capital assets. This brings the total number of open priority recommendations to 22. (See enclosure for the list of recommendations and actions needed to address them.)

The 22 priority recommendations fall into the following 9 major areas:

1. Veterans' Access to Timely Health Care.

Since 2012, we and others have expressed concerns about the Veterans Health Administration's (VHA) difficulties in providing and effectively overseeing timely access to health care for veterans, including primary care. Fully implementing two priority recommendations would help VHA (1) identify areas that need improvement and mitigate problems that contribute to longer wait times, and (2) develop an effective oversight process that ensures adequate monitoring of Veterans Integrated Service Network (VISN) activities.

2. Veterans Community Care Program.

Since 2014, we and others have highlighted weaknesses in VHA's operation and oversight of its community care programs, such as not specifying the maximum amount of time veterans should have to wait to receive such care.³ VA must ensure that veterans receive timely and quality care under this new program. Fully implementing four priority recommendations would improve the Veterans Community Care Program, including by helping VHA identify delays in care for key sex-specific services, and help ensure that all veterans receive timely access to care in the community.

3. Human Capital Management.

A strong workforce capable of providing quality and timely care to veterans is critical to the success of VA. Over the past two decades, we and others have expressed concern about certain VA human capital practices. Fully implementing five priority recommendations would improve VA's human capital management, including workforce planning and physician staffing.

4. Appeals Reform for Disability Benefits.

³In response to the VA MISSION Act of 2018, VA established the new Veterans Community Care Program in 2019. See VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393 (2018).

The Veterans Appeals Improvement and Modernization Act of 2017 required changes to VA's appeals process, giving veterans various options for having their disability claims reviewed.⁴ In 2018, we reported that VA's plan for implementing a new disability appeals process did not explain how VA would assess the new process compared to the legacy process, and it did not fully address risks associated with implementing a new process.

VA implemented appeals reform in February 2019. However, many of the principles of sound planning practices that informed our recommendations remain relevant to ensuring the new process meets veterans' needs. Fully implementing two priority recommendations to assess the performance of the new appeals process and address risks associated with implementing the new process would help VA improve appeals reform for disability benefits.

5. Quality of Care and Patient Safety.

In recent years, we have raised concerns about patient safety and the quality of care delivered in some VA medical centers. For example, in February 2019, we found that VHA had not issued policies pertaining to the circumstances in which a Drug Enforcement Administration (DEA) waiver should be obtained such as when employing providers who have had their DEA registrations for prescribing controlled substances revoked or surrendered for cause. Until VA fully implements our one priority recommendation regarding developing such policies, there is a risk that state and DEA controlled-substance requirements may not be followed.

6. Veteran Suicide Prevention.

Under various VA policies, VA facilities are required to report information about on-campus suicides to VA's leadership. In September 2020 we found that VHA does not have accurate information on how many veterans have died by suicide, and its efforts to prevent future on-campus suicides is limited by its decision not to comprehensively analyze the issue. Implementing two priority recommendations would improve the accuracy of VHA's numbers of on-campus suicides, and would help VA understand the prevalence and nature of such suicides and to address them.

7. VA Health Care System Efficiency.

It is critical that VHA closely monitor and account for how its funds are allocated to VA medical centers and redistributed throughout the year to help ensure the most efficient use of funds. In 2019, we found, for example, that some VISNs increased allocations to VA medical centers with decreasing or relatively flat workloads. Until VA fully implements our priority recommendation to revise its existing guidance to VISNs about funding allocations, it increases the risk that these allocation adjustments will not align with its strategic plan, which calls for the efficient allocation of funds.

8. Acquisition Management.

Federal agencies, including VA, face significant, long-standing acquisition management challenges that increase the risk of waste and mismanagement. For example, in March 2021, we testified that the COVID-19 pandemic exposed problems in VA's supply chain management and highlighted the need for a comprehensive supply chain management strategy. Fully implementing three priority recommendations, such as using a balanced set of performance

⁴Pub. L. No. 115-55, 131 Stat. 1105 (2017).

metrics to manage the department's procurement organizations, would help improve VA's acquisition management.

9. VA's Capital Asset Management.

VA manages a vast portfolio of capital assets and has pressing requirements associated with planning for these assets, such as adapting to changes in veterans' demographics, needs, and expectations. In addition, VA faces challenges meeting some of the key GAO-identified characteristics of an asset management framework, such as the need to continuously assess the performance of its asset management system. Fully implementing two priority recommendations—including developing and using a set of performance goals and related measures to assess the performance of its capital assets—will help VA improve its capital planning and asset management to better serve veterans.

In March 2021, we issued our biennial update to our [High-Risk List](#), which identifies government operations with greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.⁵ Two of our high-risk areas—[Managing Risks and Improving VA Health Care](#) and [VA Acquisition Management](#)—center directly on VA. Three additional high risk areas—[Improving and Modernizing Federal Disability Programs](#); [Improving Federal Management of Programs that Serve Tribes and Their Members](#); and [National Efforts to Prevent, Respond to, and Recover from Drug Misuse](#)—are shared among VA and other agencies.

Several other government-wide high-risk areas also have direct implications for VA and its operations, including (1) [Improving the Management of IT Acquisitions and Operations](#), (2) [Strategic Human Capital Management](#), (3) [Managing Federal Real Property](#), (4) [Government-wide Personnel Security Clearance Process](#), and (5) [Ensuring the Cybersecurity of the Nation](#).⁶ In particular, we encourage you to give attention to our recommendations related to strengthening the access controls and security configurations of VA's high-impact systems. Continued vigilance in this area is needed.⁷

We urge your attention to the two VA high-risk areas and to the other high-risk areas as they relate to VA. Progress on high-risk issues has been possible through the concerted actions and efforts of Congress, the Office of Management and Budget (OMB), and the leadership and staff in agencies, including within VA. In March 2022, we issued a report on key practices to

⁵GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, [GAO-21-119SP](#) (Washington, D.C.: Mar. 2, 2021).

⁶With regard to cybersecurity, we also urge you to use foundational information and communications technology supply chain risk management practices set forth in our December 2020 report: GAO, *Information Technology: Federal Agencies Need to Take Urgent Action to Manage Supply Chain Risks*, [GAO-21-171](#) (Washington, D.C.: Dec. 15, 2020).

⁷This letter does not include priority recommendations related to strengthening the access controls and security configurations of VA's high-impact systems because the report that contained these recommendations is not publicly available. However, VA should work to implement those recommendations to better manage this important high-risk area.

successfully address high-risk areas, which can be a helpful resource as your agency continues to make progress to address high-risk issues.⁸

Copies of this report are being sent to the Director of OMB and appropriate congressional committees including the Committees on Appropriations, Budget, Homeland Security and Governmental Affairs, and Veterans' Affairs, United States Senate; and the Committees on Appropriations, Budget, Oversight and Reform, and Veterans' Affairs, House of Representatives. In addition, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

I appreciate VA's continued commitment to these important issues. If you have any questions or would like to discuss any of the issues outlined in this letter, please do not hesitate to contact me or Jessica Farb, Managing Director, Health Care, at 202-512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Our teams will continue to coordinate with your staff on all of the 208 open recommendations. Thank you for your attention to these matters.

Sincerely yours,

A handwritten signature in black ink that reads "Gene L. Dodaro". The signature is fluid and cursive, with a long horizontal stroke extending to the right from the end of the name.

Gene L. Dodaro
Comptroller General
of the United States

Enclosure – 1

cc: The Honorable Shalanda Young, Director, OMB

⁸GAO, *High-Risk Series: Key Practices to Successfully Address High-Risk Areas and Remove Them from the List*, [GAO-22-105184](#) (Washington, D.C.: Mar 3, 2022).

Enclosure

Priority Open Recommendations to the Department of Veterans Affairs (VA)

1. Improving Oversight of Veterans' Access to Timely Health Care

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 Veterans Affairs 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.

Action Needed: VA agreed with our recommendation. According to VA officials, the department is in the process of implementing a new scheduling system (integral to its new electronic health record system) that officials believe is a key part of addressing our recommendation, with a targeted national completion date of 2027 for implementation across all VA health care facilities. Given our continued concerns about the Veterans Health Administration's (VHA) ability to ensure the reliability of the wait-time data and the distant completion date of VA's new scheduling system, VHA should clarify its existing policy and provide additional details and documentation regarding how the new scheduling system will address these concerns. Until VHA improves the reliability of its medical appointment wait time measures, VHA is less equipped to identify areas that need improvement and mitigate problems that contribute to longer wait times.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

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

Recommendation: The Under Secretary for Health should establish a comprehensive policy that clearly defines Veterans Integrated Service Network (VISN) roles and responsibilities for managing and overseeing medical centers.

Action Needed: VHA concurred in principle with our recommendation. In September 2021, VHA issued Directive 1217.01, which outlined the roles, responsibilities, and decision rights for the VHA Governance Board. However, VHA has not provided documentation on how the Governance Board or Directive 1217.01 will address or establish clear VISN-level responsibilities for medical center oversight, including any specific policies or directives that comprehensively outline this process and responsibilities in detail. The lack of clearly defined roles and responsibilities at the VISN level makes it difficult for VHA to develop an effective oversight process that ensures adequate monitoring of VISN activities.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

2. Improving Oversight of the Veterans Community Care Program

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 Veterans Affairs 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. In June 2022, VHA said it can monitor the driving times to appointments monthly. However, for monitoring appointment scheduling and completion times, VHA said any additional efforts would require a contract modification that would be both time and cost prohibitive. For reasons appointments cannot be scheduled, VHA said its Office of Integrated Veteran Care does not have the capacity to conduct this kind of monitoring.

To implement this recommendation, VHA needs to provide documentation that, as a part of its community care program, there is a monitoring plan (including time frames, data analyzed, and actions taken) to not only examine timely appointment scheduling and completion times for mammography, maternity care, and gynecology services, but also driving times to these appointments and reasons appointments could not be scheduled with community providers. If VHA monitored access to sex-specific care for women veterans in its community care program, it would have feedback and data to identify any delays in care and to take appropriate actions to minimize future occurrence.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

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 veterans' (1) referrals must be processed, (2) appointments must be scheduled, and (3) appointments must occur, which are consistent with the wait-time goal VHA has established for the program.

Action Needed: In July 2021, VA officials stated that they restarted plans to establish an overall wait-time performance measure for the Veterans Community Care Program. As of April 2022, VA has not provided evidence of its completion.

To fully implement these recommendations, VHA will need to complete the following actions: (1) establish an overall wait-time performance measure for the Veterans Community Care Program; (2) design an appointment scheduling process for the program that is in keeping with the established wait-time performance measure 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; and (4) determine if veterans are receiving community care within time frames that are comparable to the amount of time they would wait to receive care at VA medical facilities. By not addressing these recommendations, VA increases its risk of not being able to ensure that all veterans receive timely access to care in the community.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care. GAO-20-643. Washington, D.C.: September 28, 2020.

Recommendation: The Under Secretary of Health should align its monitoring metrics with the time frames established in the Veterans Community Care Program scheduling process.

Action Needed: In February 2022, VA officials stated that while the agency previously disagreed with this recommendation, it has matured enough in its practices and ability to track data to act on the recommendation. VA officials said the department released an updated version of VHA Directive 1232, Consult Processes and Procedures, in January 2022, which reflects metrics for VA medical centers to follow specific to time frames established in the Veterans Community Care Program. Among other things, VA aligned one of the referral metrics to the Veterans Community Care Program appointment scheduling process, and created a metric for an average time for a referral to be scheduled.

To fully implement this recommendation, VA still needs to establish a time frame to account for the entire Veterans Community Care Program appointment scheduling process, and once done, ensure its current scheduling time frames and monitoring metrics align with the goal. Without monitoring metrics that are consistent with VA policy, VA's ability to identify high- and low-performing VA medical centers is limited. The use of inconsistent metrics also affects VA's ability to work with VA medical centers to identify problems and implement corrective actions to improve the timeliness of veterans' appointments, as needed.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

3. Improving Management of Human Capital

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, 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.

Action Needed: VA partially agreed with our recommendation and has taken important steps toward addressing it. Specifically, in May 2020, VA implemented an enterprise-wide performance management system that features department-wide training, covering employees under Title 5, Title 38, and Title 38-Hybrid. VA also revised its performance management policy for Title 5, Title 38, and Title 38-Hybrid positions, which it still has not implemented. To fully implement the recommendation, VA needs to develop and implement a process to standardize performance plan elements, standards, and metrics for common positions across VHA. Until VA finalizes its revised performance management policy, which it estimated placing into concurrence no later than the third quarter of fiscal year 2022, VA may not be positioned to make meaningful distinctions in employee performance.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Acting Director: Alissa Czyz, Strategic Issues

Contact information: czyza@gao.gov, (202) 512-6806

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.

Action Needed: VHA officials disagreed with the recommendation and, as of February 2022, had not taken any action. Although VA responded to our report by stating that the ability to count physicians does not affect its ability to assess workload, we maintain that an accurate count of all physicians providing care at each medical center is necessary for accurate workforce planning.

To implement the recommendation, VHA needs to develop a system-wide process to collect information on all physicians providing care at VA medical centers, including physicians that are not employed by VHA. The lack of ready access to complete information on all types of physicians, including physicians who provide care under arrangements other than VA employment, means VHA does not have a consistent, systemic count of its total physician workforce. As such, VHA cannot ensure that its workforce planning process sufficiently addresses gaps in physician staffing, including whether staffing is appropriately allocated across VA medical centers and departments, which may affect veterans' access to care, among other issues.

High Risk Area: [Managing Risks and Improving VA Health Care, Strategic Human Capital Management](#)

Director: Sharon M. Silas, Health Care

Contact information: silass@gao.gov, (202) 512-7114

Department of Veterans Affairs: Improved Succession Planning Would Help Address Long-Standing Workforce Problems. [GAO-20-15](#). Washington, D.C.: October 10, 2019.

Recommendation: The Secretary of Veterans Affairs should develop a department-wide succession plan for leadership and mission-critical occupations that incorporates key leading practices for succession planning.

Action Needed: VA concurred with our recommendation. To implement this recommendation, VA needs to develop a succession plan for its leadership positions as well as for occupations identified as mission-critical. VA reported that it is developing a department-wide succession plan for leadership and mission-critical occupations that will incorporate leading practices. As of March 2022, VA reported that it did not have an estimated publishing date for this plan. Establishing a succession plan would help VA identify and develop high-potential staff to meet VA's mission over the long term.

High Risk Area: [Strategic Human Capital Management](#)

Acting Director: Alissa Czyz, Strategic Issues

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Sexual Harassment: Inconsistent and Incomplete Policies and Information Hinder VA's Efforts to Protect Employees. [GAO-20-387](#). Washington, D.C.: June 15, 2020.

Recommendation: VA's Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness should realign VA's Equal Employment Opportunity (EEO) Director position to adhere to the applicable Equal Employment Opportunity Commission (EEOC) directive by ensuring the position is not responsible for personnel functions.

Action Needed: VA did not agree with our recommendation. Nevertheless, in September 2020, VA met with the EEOC to discuss, among other things, alignment of VA's EEO Director position. VA plans to continue to work with EEOC to assess the alignment of this position. In February 2022, VA said that it continues to explore options to address our recommendation but did not have specific plans for doing so. To implement our recommendation VA needs to realign the EEO Director position, in accordance with the EEOC directive. Continuing to have the same person in charge of general oversight of EEO complaint processes and personnel actions can create, at a minimum, the appearance of a conflict of interest and erode employees' trust that sexual harassment complaints will be handled appropriately.

Recommendation: VA's Deputy Assistant Secretary for Resolution Management should complete VA's EEO Program Manager realignment initiative at the Veterans Benefits Administration (VBA) and VHA in accordance with VA policy.

Action Needed: VA agreed with our recommendation. As of April 2022, VBA had realigned most of its EEO Program Managers and proposed plans to complete the remaining realignment this year. VA stated in April 2022 that it has no plans to realign VHA EEO Program Managers. To implement our recommendation VA needs to complete the realignment of EEO Program Managers at both VBA and VHA because not doing so would continue to hinder VA's efforts to prevent and address sexual harassment in the workplace by creating a real or perceived conflict of interest when handling EEO issues.

Managing Director: Cindy S. Brown Barnes; Education, Workforce, and Income Security

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4. 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 Veterans Affairs 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 VBA appeals options and the Board of Veterans' Appeals (Board) dockets, and measures of accuracy, veteran satisfaction, and cost—and related baseline data.

Action Needed: VA agreed with our recommendation. In May 2021, VA established timeliness goals for all new appeals options and in February 2022 reported on a range of performance metrics for the new and legacy appeals processes. Moreover, VA officials said they are taking steps to develop a methodology to compare the legacy and new appeals processes. To fully implement our recommendation, VA needs to establish (1) a balanced set of performance goals and measures for all new appeals options, including accuracy and veterans' satisfaction, as well as (2) a methodology for assessing how well the new process is performing relative to the legacy process. Until VA takes such action, it could inadvertently incentivize staff to focus on certain aspects of appeals performance over others or fail to improve overall service to veterans.

Recommendation: The Secretary of Veterans Affairs 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.

Action Needed: VA agreed with our recommendation and took several steps to identify risks prior to implementing its new disability appeals process. To fully implement our recommendation, VA will need to more fully address workload risks and assess risks against a balanced set of goals, such as accuracy and timeliness of decisions or veterans' satisfaction. Even after implementing the new appeals process, many of the principles of sound planning practices that informed our recommendation remain relevant. VA needs to continue applying these principles to better address risks associated with implementing the new process. For example, the Board's new hearing option—the most resource intensive of several options—accounted for almost 55 percent of the new appeals inventory as VA prioritizes other workloads and addresses COVID-19-related slowdowns in hearings. This circumstance could mean veterans will have longer wait times under this hearing option.

High Risk Area: [Improving and Modernizing Federal Disability Programs](#)

Director: Elizabeth H. Curda; Education, Workforce, and Income Security

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5. Ensuring Safe, High-Quality Care for Veterans

Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care. [GAO-19-6](#). Washington, D.C.: February 28, 2019.

Recommendation: The Under Secretary for Health should develop policies and guidance regarding Drug Enforcement Administration (DEA) registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies.

Action Needed: VA agreed with our recommendation. In December 2021, VA said that an Interdisciplinary Project Team is working to identify VA's approach to management and oversight of DEA waivers, which was still ongoing as of June 2022. To fully implement this recommendation, VA needs to provide evidence of actions taken to ensure that DEA requirements regarding DEA registrations and employment waivers are met. Such actions include developing policies regarding when a DEA employment waiver may be necessary and guidance about how to request such a waiver. Until VA takes such action, there is a risk that state and DEA controlled-substance requirements may not be followed.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Seto Bagdoyan, Forensic Audits and Investigative Service

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6. Improving VA's Efforts to Prevent Veteran Suicides

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

Recommendation: The Under Secretary for Health should, in collaboration with relevant VBA and National Cemetery Administration (NCA) officials, improve its process to accurately identify all on-campus veteran deaths by suicide by ensuring that it uses updated information and corroborates information with VA facility officials.

Action Needed: VA agreed with our recommendation and stated that it established a standing committee that includes representatives from VHA, VBA, NCA, and the Office of Operations, Security, and Preparedness. In January 2022, VHA told us that the committee drafted changes to its directive to require notification of all veteran suicide deaths on VA property to the Office of Mental Health and Suicide Prevention, to include procedures for email notification, reconciliation, and corroboration from local officials. To fully implement this recommendation, VHA needs to complete development of its process to collect accurate data for on-campus veteran deaths by suicide and ensure that it uses updated information and corroborates information with all VA facilities. Without doing so, VHA's numbers of on-campus suicides are inaccurate.

Recommendation: The Under Secretary for Health should expand the policy requirement for a root cause analysis to include all cases of on-campus veteran death by suicide, regardless of whether the veterans involved were enrolled in VHA health care services at the time of their death.

Action Needed: VA disagreed with this recommendation by stating that a root cause analysis was not the appropriate tool for conducting suicide surveillance for all cases. VA noted that a committee would identify methods for enhancing trend analysis and expanding existing VHA reporting to include VBA and NCA, such as issue briefs that VHA is required to write for all suicide attempts and deaths that occur at medical centers. However, we continue to believe that, until VHA develops methods for expanding existing VHA reporting, VHA should consider performing a root cause analysis because it is an existing process that could easily be expanded to examine all on-campus veteran suicides.

To implement this recommendation, VHA needs to ensure that, for all on-campus deaths by suicide, its yet-to-be established process captures the elements found in a root cause analysis—such as what happened, why it happened, and if it could be prevented in the future. Without accurate information on the number of suicides and comprehensive analyses of the underlying causes, VA does not have a full understanding of the prevalence and nature of on-campus suicides, hindering its ability to potentially address them.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

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7. Ensuring Efficiency within the VA Health Care System

Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding. [GAO-19-670](#). Washington, D.C.: September 23, 2019.

Recommendation: The VA Under Secretary of Health should revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered.

Action Needed: VA agreed in principle with our recommendation. VHA stated that it is conducting market assessments over a multi-year period to increase access and quality of care to veterans. These market assessments were completed in March 2022. VHA said that after completing the market assessments and reviewing information from other VHA efforts, it may consider adjusting the level of services along with other alternatives.

To fully implement our recommendation, VHA needs to demonstrate it has taken these actions to adjust the level of services or taken other actions to revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency and help lower costs at medical centers with declining workloads that received adjusted funding levels. Without doing so, VHA increases the risk that these adjustments will not align with its strategic plan, which calls for the efficient allocation of funds.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Sharon M. Silas, Health Care

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8. Improving Acquisition Management

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 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.

Action Needed: VA agreed with our recommendation. To implement our recommendation, VA needs to develop an overarching strategy for obtaining medical surgical supplies through a prime vendor. VA had planned to implement a new Medical Surgical Prime Vendor (MSPV) program, called MSPV 2.0, starting in 2020; it has also been piloting the Defense Logistics Agency's (DLA) MSPV program since 2019. However, as of February 2022, VA's plans for the next version of its MSPV program are still being developed and its planned switch to the DLA MSPV program has been halted by a court order. As a result, there is substantial uncertainty in the path forward, and shortcomings in VA's existing MSPV program remain unaddressed.

High Risk Area: [VA Acquisition Management](#)

Director: Shelby Oakley, Contracting and National Security Acquisitions

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VA Acquisition Management: Comprehensive Supply Chain Management Strategy Key to Address Existing Challenges. [GAO-21-445T](#). Washington, D.C.: March 24, 2021.

Recommendation: The Secretary of Veterans Affairs should ensure the VHA Assistant Under Secretary for Health for Support develops a comprehensive supply chain management strategy that outlines how VHA's various supply chain initiatives are related to each other and to VA-wide initiatives. This strategy should link to VA's overall plans to address its broader acquisition management challenges and reflect key practices of organizational transformations, including an implementation plan with key milestones.

Action Needed: VA officials expressed verbal agreement with this recommendation. To implement it, VA needs to develop a comprehensive supply chain management strategy that addresses the interrelationships between its various modernization relationships and reflects key practices of organizational transformations, including an implementation plan with key milestones. As of February 2022, VA's Chief Acquisition Officer has begun leading efforts to develop an overarching strategy. VA has completed the first two phases of its process to develop this strategy, which includes identifying the current state of its supply chain and a supply chain gap analysis. As part of the next phase, VA's Office of Acquisition, Logistics, and Construction will develop a supply chain strategy. Until it develops an overarching supply chain strategy and answers key questions, VA will not be able to fully address its high-risk acquisition management and ultimately better meet veterans' needs.

High Risk Area: [VA Acquisition Management](#)

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Federal Contracting: Senior Leaders Should Use Leading Companies' Key Practices to Improve Performance. [GAO-21-491](#). Washington, D.C.: July 27, 2021.

Recommendation: The Secretary of Veterans Affairs should ensure the VA Senior Procurement Executive (SPE) uses a balanced set of performance metrics to manage the department's procurement organizations, including outcome-oriented metrics to measure (a) cost savings/avoidance, (b) timeliness of deliveries, (c) quality of deliverables, and (d) end-user satisfaction.

Action Needed: VA agreed with this recommendation. As of February 2022, VA has begun initial work to develop metrics. To fully implement this recommendation, VA needs to develop and use a balanced set of performance metrics—including outcome-oriented metrics—to manage the department's procurement organizations. Doing so would help VA identify improvement opportunities, set priorities, and allocate resources.

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9. Improving VA's Capital Asset Management

VA Real Property: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations. [GAO-19-440](#). Washington, D.C.: June 13, 2019.

Recommendation: To improve VA's ability to plan for and align its facilities with estimated changes to veterans' needs and expectations, we recommend that the Secretary of Veterans Affairs ensure the appropriate offices and administrations instruct VA medical centers on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources or tools and directing VA medical centers to use them.

Action Needed: VA agreed with the recommendation and indicated that it would instruct users on what data to use in planning and updates, which would help ensure veterans' input is incorporated where appropriate. As part of that effort, in January 2020 VA issued guidance to VA medical centers. In particular, this guidance instructed users how to ensure that planning is consistent with veterans' needs. However, to fully implement our recommendation, VA needs to instruct the VA medical centers how to ensure that this planning is also consistent with veterans' changing expectations. As of February 2022, VA did not have an update on its efforts to provide this guidance. Without providing clear instruction, VA increases its risk that the VA medical centers' planning is not meeting VA's strategic goal to incorporate veterans' changing expectations.

High Risk Area: [Managing Risks and Improving VA Health Care](#)

Director: Andrew Von Ah, Physical Infrastructure

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VA Real Property: Enhanced Communication and Performance Measurement Could Improve Capital Asset Management. [GAO-22-103962](#). Washington, D.C.: October 29, 2021.

Recommendation: The Secretary of Veterans Affairs should develop a set of performance goals and related measures based on key practices to allow VA to assess the performance of its capital assets and make any necessary improvements to its management of those assets.

Action Needed: VA agreed with our recommendation. In June 2022, VA stated that it has established a working group to review existing performance metrics and develop new metrics to best track progress towards VA's strategic goals. To fully implement this recommendation, VA needs to provide evidence the group has completed its planned work, such as a performance measurement framework, including new metrics and explicit goals, for capital assets, and an implementation plan for the metrics so VA can utilize this information in strategic capital decisions. The working group's target completion date for implementation is August 2022. Without fully implementing this recommendation, VA is limited in its ability to determine the

extent to which its asset management is helping VA to achieve its strategic goals and objectives.

High Risk Area: [Managing Federal Real Property](#)

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