

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

Why GAO Did This Study

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

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

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

What GAO Recommends

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

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

VA HEALTH CARE

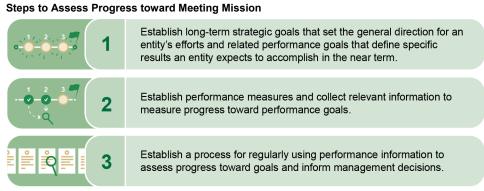
Office of the Medical Inspector Should Strengthen Oversight of Recommendations and Assess Performance

What GAO Found

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

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

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



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

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