1. OIG and GAO-Identified Management Challenges/Issues

Introduction

The Department of Veterans Affairs (VA) Performance and Accountability Report (PAR) at http://www.va.gov/budget/report/ provides results on VA's progress towards providing America's veterans with the best in benefits and health care.

The PAR contains performance targets and results achieved during a fiscal year for specific strategic goals. For FY 2008 those strategic goals were:

Strategic Goal 1 - Honoring, Serving, and Memorializing Veterans

Strategic Goal 2 - Restoration and Improved Quality of Life for Disabled Veterans

The PAR also identifies an "enabling goal" of "Applying Sound Business Principles."

OIG Major Management Challenges for Strategic Goal 1: Honoring, Serving, and Memorializing Veterans

OIG Challenge 1: Health Care Delivery

The quality of veteran health care is the most critical issue facing the Veterans Health Administration (VHA) today. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA. Over the past 7 years, OIG has invested about 40 percent of its resources in overseeing the health care issues impacting our Nation's veterans and has conducted reviews at all VA Medical Centers (VAMC) as well as national inspections and audits, issue-specific Hotline reviews, and investigations. VHA faces challenges in managing its health care activities, with particular concern noted in the quality of care, mental health needs of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans, and VHA research activities.

OIG Challenge 1A: Quality of Care

OIG continues to assess the quality of care at delivery points throughout VA, with significant challenges noted in access to care for rural health, elder care, credentialing and privileging, the Home Respiratory Care Program (HRCP), and systemic problems with outpatient scheduling and patient waiting times.

The OIG Combined Assessment Program (CAP) inspection process highlights that VHA provides quality health care at many facilities. However, medical and supportive care provided to veterans who do not live close to a facility is less consistently available. OIG finds that veterans who live in rural areas may not have readily available access to specialty care, even at a further distance from their local community. This difficulty in the provision of specialty care across the country means that it is challenging, if not impossible, to provide a standard health care benefit to all enrolled veterans.

In addition, VHA has made only limited progress in addressing the longstanding and underlying causes of problems with outpatient scheduling, accuracy of reported waiting times, and completeness of electronic waiting lists (EWLs). Of concern is VHA's delay in implementing

appropriate quality assurance procedures necessary to ensure the reliability of waiting times and waiting lists. Audits of outpatient scheduling and patient waiting times completed since 2005 have identified noncompliance with policies and procedures for scheduling, inaccurate reporting of patient waiting times, and errors in EWLs. Although VHA has recognized the need to improve scheduling practices and the accuracy of waiting times data, no meaningful action has been taken to achieve this goal to date. Nine recommendations in prior OIG audit reports issued in 2005 and 2007 that were agreed to by VHA remain unimplemented, as confirmed by our most recent follow-up work in this area in 2008.

The May 2008 OIG report on Veterans Integrated Service Network (VISN) 3 waiting times determined scheduling procedures were not followed, which affected the reliability of reported waiting times and caused inaccuracies in EWLs. OIG recommended that the Under Secretary for Health establish procedures to routinely test the accuracy of reported waiting times and completeness of EWLs, as well as take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and those documented in VHA's scheduling system. This report and prior reports indicate that the problems and causes associated with scheduling, waiting times, and waiting lists are systemic throughout VHA. Moreover, VHA has not ensured compliance with its policy that patients' preferences for desired appointment dates are documented and that veterans receive appointments within the required timeframes. Scheduling roughly 40 million appointments annually, VHA needs to properly document desired appointment dates and ensure patient waiting times are accurate. This is not only a data integrity issue in which VA reports unreliable performance data; it affects quality of care by delaying—and potentially denying—deserving veterans timely care.

A separate, but nevertheless urgent, issue relates to the improvements needed in VHA's credentialing and privileging process. Credentialing refers to the process by which health care organizations screen and evaluate medical providers in terms of licensure, education, training, experience, competence, and health status. OIG identified that providers' previously undisclosed medical licenses create significant problems due to their unmonitored status. OIG also found significant deficiencies in the privileging of physicians, which is the process by which physicians are granted permissions by the medical center to perform specific diagnostic and therapeutic procedures. Providers' privileging for diagnostic and therapeutic interventions is not always appropriate to the capabilities of the medical staff and facilities. Over time, VHA has developed extensive and detailed procedures for credentialing and privileging; however, standardization of these processes and adherence to VHA guidance must be improved to ensure appropriately qualified staff.

Although much appropriate attention has been focused on younger, more recent combat veterans, a large percentage of veterans who are dependent on VA for care are those elderly veterans who are in contract community nursing homes (CNHs). Vulnerabilities in this important program continue to exist, including lack of program oversight, lack of standardized inspection procedures, and inconsistency in local VA medical center review team composition and processes, including the regularity and documentation of visits.

To cite a specific example of quality of care issues identified by OIG oversight work, audits of VHA's HRCP found that VHA facilities had not established home respiratory care teams or completed quarterly program reviews as required. Facility staff did not timely and consistently