U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

STRATEGIC PLAN 2022–2026

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

VISION

To perform audits, inspections, investigations, and reviews that improve the efficiency, effectiveness, and integrity of the Department of Veterans Affairs' programs and services.

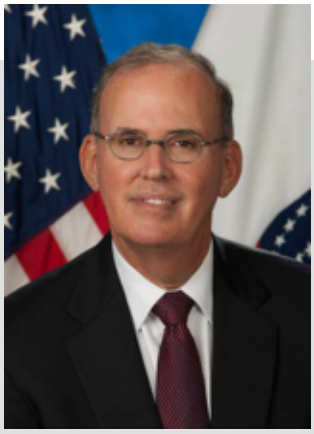
To achieve this vision, the Office of Inspector General (OIG) will

- identify and prioritize work that will have the greatest impact on the lives of veterans, their families and caregivers, and on VA resources and operations;
- prevent and address fraud and other crimes, waste, and abuse, as well as advance efforts to hold responsible individuals accountable;
- help ensure eligible veterans and other beneficiaries receive prompt and high-quality health care, services, and benefits by issuing accurate, timely, and objective reports; and
- make meaningful data- and evidence-driven recommendations that enhance VA programs or operations and promote the appropriate use of taxpayer dollars.

VALUES

- Protect individuals who allege wrongdoing and treat them with respect and dignity
- Promote diversity, inclusion, and equal opportunities within the OIG and a climate that attracts and retains the highest-quality staff
- Meet the highest standards of integrity, professionalism, and accountability
- Safeguard the OIG's independence and maintain transparency
- Honor veterans and all those who serve them by continually striving for excellence

Letter from the Inspector General



I am pleased to present the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Strategic Plan for 2022–2026. The mission of the VA OIG is to conduct effective oversight of the largest integrated healthcare system in the nation, VA's benefits and services, and the many other programs that collectively serve millions of veterans, their families, and caregivers.

Our office of approximately 1,100 dedicated professionals promotes the effectiveness, efficiency, and integrity of VA programs and operations for the benefit of all those they serve. Our focus is not just on programs and personnel, but on the governance, leadership, culture of accountability, and innovation-driven infrastructure that are essential to VA's success.

VA leaders and personnel, veterans, veterans service organizations, Congress, and taxpayers are among those looking to us to ensure we root out potential crimes, waste, and abuse and encourage meaningful improvements to VA through effective recommendations and data-supported findings. This strategic plan is our roadmap to performing that work and living up to the trust that has been placed with us.

We have five strategic goals that relate to overseeing health care, benefits, fiscal responsibilities, leadership, and innovation. The related objectives and strategies are outlined together with performance measures and examples of our work in each area. This strategic plan guides our work to ensure it is impactful, fair, transparent, and makes the best use of taxpayer dollars. It is supported by the values to which all OIG employees are committed. Our efforts continue to improve diversity, equity, and inclusion within our office to attract and retain staff with wide-ranging experiences and perspectives that make us stronger and more effective as an organization. OIG staff are trained to conduct their work to meet strict standards of integrity, professionalism, and accountability, consistent with OIG values. Those values ensure that anyone who shares concerns of wrongdoing with our staff will be treated with dignity and respect. They safeguard the OIG's independence and the transparency of our work. It is through this commitment to excellence in our work that OIG staff honor veterans and advance the efforts of the VA leaders and personnel who serve them.

MICHAEL J. MISSAL
Inspector General

Last updated December 2021

What We Do

Criminal, Waste, and Abuse Investigations

Audits, Inspections, and Reviews

Healthcare Oversight

Benefits, Services, and Program Oversight

OIG Hotline Responses

Efficiency Recommendations

Contents

Strategic Goals

The OIG's strategic goals remain responsive to areas of need identified from information provided by veterans and their families, veterans service organizations, VA personnel, and Congress, as well as from the OIG's proactive and data-driven efforts. These goals will be advanced through VA OIG audits, inspections, reviews, evaluations, and investigations that have the greatest impact on veterans' lives, investments of taxpayer dollars, and the public interest.

Goal 1

Help ensure veterans receive prompt access to exemplary health care by identifying opportunities to improve the quality, management, efficiency, and delivery of patient-centered care in VA facilities and in the community.

Goal 2

Make recommendations to facilitate the swift delivery of benefits and superior services to eligible veterans, their families, and caregivers by addressing barriers to expeditious and accurate VA decision-making and processes.

Goal 3

Identify and implement procedures and strategies for making the most responsible use of VA's appropriated funds, including sound procurement policies, closely monitored spending, and financial practices that reduce the risk of fraud, waste, and misuse of resources.

Goal 4

Address failures in governance and leadership—including lack of accountability, splintered and ineffective management, staffing deficits, and misconduct by individuals in positions of trust—that contribute to emergent, pervasive, and persistent problems within VA.

Goal 5

Encourage innovation and recommend enhancements to VA's infrastructure and systems through findings and report recommendations that address information technology, data security, predictive tools, and financial management systems.

Objectives

The OIG's goals and objectives address areas for which persistent problems have been identified within VA. In many cases they align with VA's own goals to be a high-reliability organization committed to meeting veterans' needs. Major management challenges, areas of congressional concern, and risks identified by other oversight entities are also considered. They target VA's core functions, systems, infrastructure, operations, and services. Through these objectives, the OIG helps improve VA and hold those accountable who commit fraud and other crimes, waste, and abuse.

Goal 1

Help ensure veterans receive prompt access to exemplary health care

1.1. Recommend ways to strengthen the quality of care offered by VA and its community providers and improve the delivery of care in an array of settings

1.2. Promote access to healthcare providers who are qualified to address veterans' often distinct physical and behavioral health needs in a timely manner

Examples of OIG work areas:

- *Healthcare encounters and how care is delivered*
- *Credentialing and privileging of VA healthcare providers*
- *Patient safety, including supporting systems and services*

Goal 2

Make recommendations to facilitate the swift delivery of benefits and superior services to eligible veterans, their families, and caregivers

2.1. Recommend improvements in decision-making and accountability at every stage in the benefits process—from eligibility determinations through delivery and appeals

2.2. Advance the quality and delivery of VA services, such as military transitional assistance, home loans, training and education, and fiduciary and caregiver support

Examples of OIG work areas:

- *Accuracy of eligibility determinations*
- *Claims processing precision and timeliness*
- *Compliance with statutory expansions of eligible beneficiaries and new coding systems*

Objectives (continued)

Goal 3

Identify and implement procedures and strategies for making the most responsible use of VA's appropriated funds, including sound procurement policies, closely monitored spending, and financial practices that reduce the risk of fraud, waste, and misuse of resources

3.1. Identify potential savings and monetary recoveries by scrutinizing VA's financial management and controls, high-risk programs, and process efficiencies

3.2. Focus criminal investigations on holding employees, contractors, and others accessing VA resources accountable for illegal activities; and for administrative investigations, help ensure senior leaders are held responsible for wrongdoing or unethical conduct

Examples of OIG work areas:

- *Systems controls that minimize user errors that lead to overpayments and avoidable losses*
- *Data outliers and other indicators of potential fraud or other crimes, waste, and abuse*
- *Reliability and completeness of VA reporting on cost projections and spending*

Goal 4

Address failures in governance and leadership, as well as misconduct by individuals in positions of trust

4.1. Examine governance structures to determine if reporting lines and information-sharing mechanisms are effective and encourage efficient VA operations and program implementation

4.2. Establish the causes—and who is accountable—for identified problems, including lack of policies or guidance, leaders' inaction, and failures to deliver quality care or services by staff entrusted with veterans' safety and well-being

Examples of OIG work areas:

- *Stability, effectiveness, and quality of leadership and governance*
- *Possible violations of law by or against veterans or VA personnel, assets, and property that also may include making false statements or impeding investigations*
- *Senior leaders' misconduct, abuse of authority, and unethical actions*

Objectives (continued)

Goal 5

Encourage innovation and recommend enhancements to VA's infrastructure and systems, including IT, data security, predictive tools, and financial management systems

5.1. Identify promising practices and innovation through OIG work or through exchanges with VA staff and veterans' groups, and recognize progress made by VA in implementing OIG recommendations

5.2. Review current and proposed financial, health record, inventory, and other IT systems for their effectiveness, cost controls, user need responsiveness, and whether information is properly used, shared, and secured

5.3. Examine VA planning and transition efforts on high-risk initiatives and recommend improvements to VA's organizational supports, policies, and guidance implementation to advance programs and operations and remedy observed problems

Examples of OIG work areas:

- *Patient electronic health record modernization scheduling, planning, implementation, and reporting*
- *Enterprise medical supply inventory management and reliability for routine and crisis implementation*
- *Financial management systems that relate to long-standing major management challenges and high risks identified by the OIG and GAO*

Key Strategies

In order to prioritize limited resources, the OIG must focus on work that will yield results with the greatest possible effect on the lives of veterans and their families. The OIG receives nearly 30,000 contacts each year through its hotline and other OIG offices. Concerns related to the effects and aftermath of the COVID-19 pandemic, and the opportunity to use lessons learned regarding alternative service and care delivery methods, have also resulted in a significant number of diverse oversight initiatives. Requests from Congress, concerns from VA, issues raised by other oversight agencies, leads from additional stakeholders, and expanded use of data analytics all contribute to a vast pool of potential oversight work.

In addressing fraud, waste, abuse, inefficiencies, and lack of effectiveness, the OIG recommends improvements to VA programs and operations and proposes approaches that result in saving and recovering taxpayer dollars whenever possible. The following are three strategies that OIG staff are using to ensure that oversight efforts are successful and have a noteworthy positive effect.

1. Focus available resources on high-impact oversight work

The OIG seeks to identify criminal activity, significant VA program and operational deficiencies, and wrongdoing through audits, inspections, reviews, and investigations.

The following criteria are among those considered in determining the potential nature, scope, and impact of oversight work that will advance the OIG's goals and objectives:

- Risk of harm to veterans and their families (both well-being and financial)
- Number of veterans affected by a particular system, process, or program change or failure
- Record of performance by VA programs or operations, including whether they are new or required to be implemented quickly
- Amount of VA funding invested in specific systems, operations, programs, or topic areas
- Substantial changes in policy, structure, or direction by VA that have the potential for eroding controls, efficiency, or effectiveness
- Areas considered high risk through OIG fieldwork or trends detected by its hotline, healthcare inspections, data analysis and modeling, investigations, or other efforts

Key Strategies (continued)

- Areas of interest reported by Congress or the veteran community, as well as high-risk areas identified by GAO or other oversight groups (internal and external to VA)
- VA contracts and third-party agreements that may require additional oversight
- The public interest

The resulting audits, reviews, inspections, and investigations generally yield reports (or summaries of judicial actions involving OIG criminal investigations) to inform VA, Congress, the veteran community, media, and public about OIG findings and recommendations. To ensure transparency, the OIG publishes all reports unless prohibited by law. These published reports are extensively disseminated and posted on the OIG website. When appropriate, OIG staff also provide outreach through news releases, social media, congressional testimony, and briefings. Reports and outreach often prompt increases in calls to the OIG hotline and provide opportunities to meet with stakeholders to exchange additional information that informs future OIG strategic work plans.

2. Improve collaborations that leverage diverse perspectives to yield high-quality, timely products

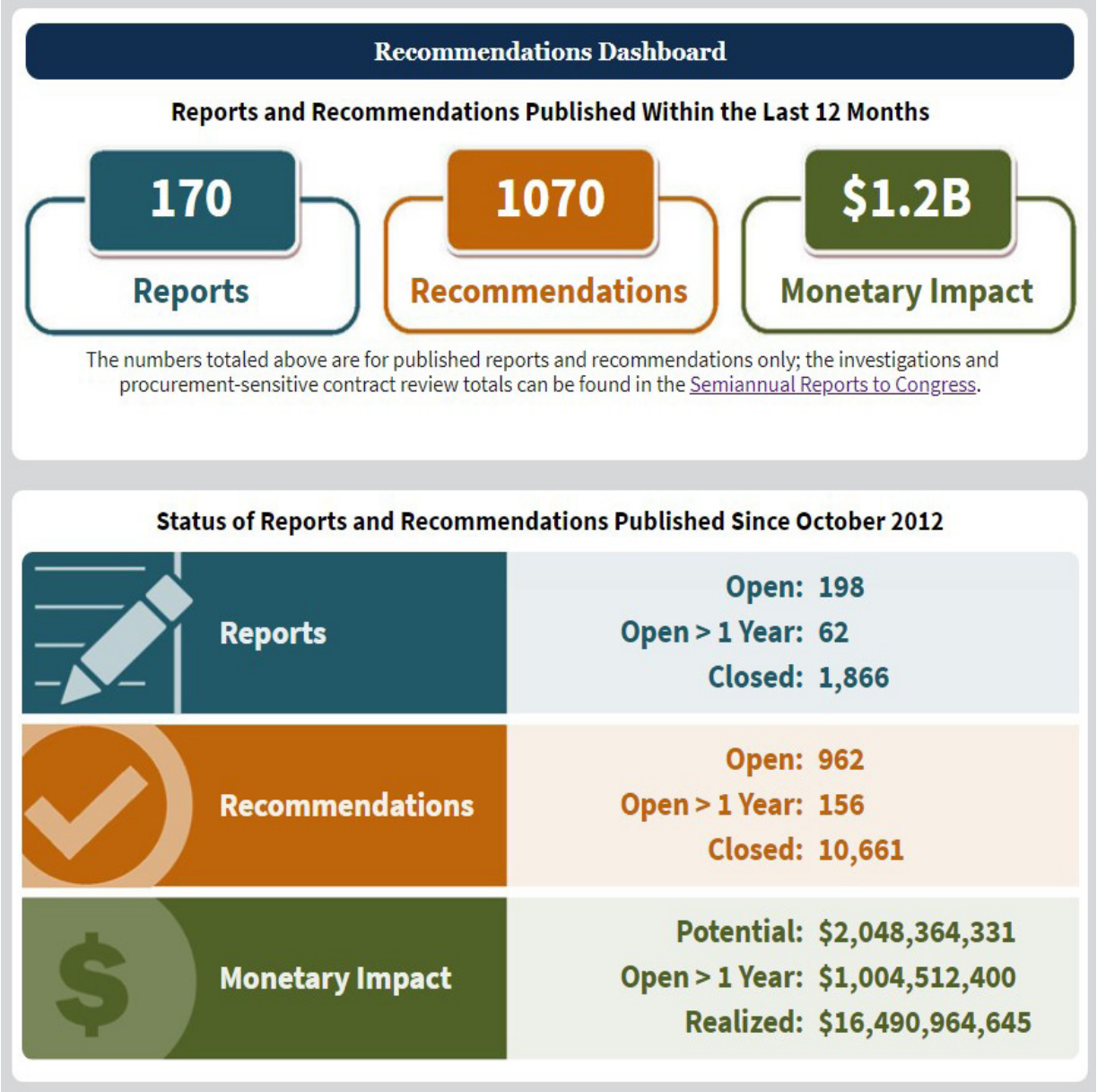
The OIG leverages expertise across its offices and uses specialized teams to get the most benefit from collaborations. Stakeholder engagement and problem-solving with VA staff are also critical to implementing OIG goals. For reports and work products to be of value to stakeholders and veterans, the OIG recognizes they must be accurate, fair, objective, thorough, and current.

The full engagement of qualified OIG staff is critical to ensuring all work is meaningful and impactful. To that end, the OIG is committed to recruiting and retaining a diverse, dedicated, and principled staff. All OIG employees are trained to conduct their work in a manner consistent with stringent ethical and quality standards and with objectivity, independence, and respect for the efforts of VA personnel on the front lines of service delivery to veterans.

3. Make recommendations to address the causes of identified problems

The OIG issues findings and recommendations that are based on available evidence, information gained from fieldwork and interviews, examination of contributing factors, and an increased use of data analytics and virtual visits as needed. OIG work that identifies areas of concern or wrongdoing also considers who is responsible, weaknesses in VA's oversight of its programs and operations, and any underlying causes of new and persistent problems. Recommendations are tracked on the VA OIG website dashboard.

Recommendations Dashboard



www.va.gov/oig/recommendation-dashboard.asp

(Screenshot from November 2021)

Outcome Measures

In assessing the effectiveness of OIG efforts, both quantitative and qualitative outcome measures are used. Because some performance measures apply to more than one goal or objective, they are summarized below. The following are among the quantitative metrics that are used to evaluate OIG efforts, consistent with previously reported performance measures:

- Percentage of reports issued that identify opportunities for improvement
- Percentage of recommendations implemented within one year to improve efficiencies in operations through legislative, regulatory, policy, practice, and procedural changes in VA (The OIG provides the recommendations dashboard on its public website to track their status as implemented/not implemented as well as in its semiannual report to Congress.)
- Monetary benefits (dollars in millions) from audits, investigations, contract reviews, and inspections
- Return on investment (monetary benefits divided by cost of operations in dollars)
- Percentage of recommended recoveries achieved resulting from postaward contract reviews
- Percentage of cases that result in criminal, civil, or administrative actions
- Number of arrests, indictments, convictions, criminal complaints, pretrial diversions, and administrative sanctions

The OIG also considers and highlights qualitative measures such as the quality of healthcare encounters; success in identifying parties responsible for recognized problems; and feedback from veterans, VA staff, whistleblowers, and other stakeholders on the quality and usefulness of OIG products. In addition, congressional interest in OIG work, hearing testimony, and other engagement that informs policy making is considered, as are changes to VA systems, policies, or practices resulting in part from OIG recommendations. All measures help inform ongoing changes to the strategic plan, which will be continually reviewed and adjusted to meet evolving needs.

Examples of Quantitative Measures

Challenges and Risks to the OIG Strategic Plan

Consistent with the provisions of the Government Performance and Results Act of 1993, the OIG has identified potential internal complications and challenges "external to the [OIG] and beyond its control" that could affect the OIG fully realizing its strategic goals.

The internal risks include the ability to quickly recruit and hire and then retain qualified staff with expertise in particular subject or specialty areas. The OIG also continues to navigate the changes needed to manage the increased shift to more remote and virtual employee supervision and collaboration triggered by the pandemic and other factors.

External challenges have included addressing rapidly changing VA guidance and tools that generate implementation concerns or complaints. OIG staff are also still limited at this writing by COVID-related precautions that complicate conducting on-site inspections and reviews. Staff and resources have been realigned to provide timely information to VA and remain responsive to its implementation of ongoing and post-pandemic efforts.

Limitations with VA systems that the OIG needs to access for vital information can be a significant impediment. Examples include VA deficiencies in implementing improvements to the supply chain, patients' electronic health record modernization, and financial management systems. The continuous onboarding of senior VA officials—many with limited prior knowledge and experience with the Department's systems and operations—and vacancies or turnover in key positions also affect OIG efforts.

Finally, the OIG is limited by its lack of subpoena power to compel testimony from former VA employees and others outside of VA who may have information relevant to its work.

Despite these challenges, the OIG remains flexible in order to be responsive to veterans, Congress, VA personnel, and others who identify exigent or emerging issues. The OIG must balance urgent concerns with more long-term oversight of matters that pose risks to VA and veterans.

OIG History and Statutory Authority

The Inspector General Act of 1978 (Public Law 95-452), as amended, established a statutory Inspector General for VA. The Inspector General has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements.

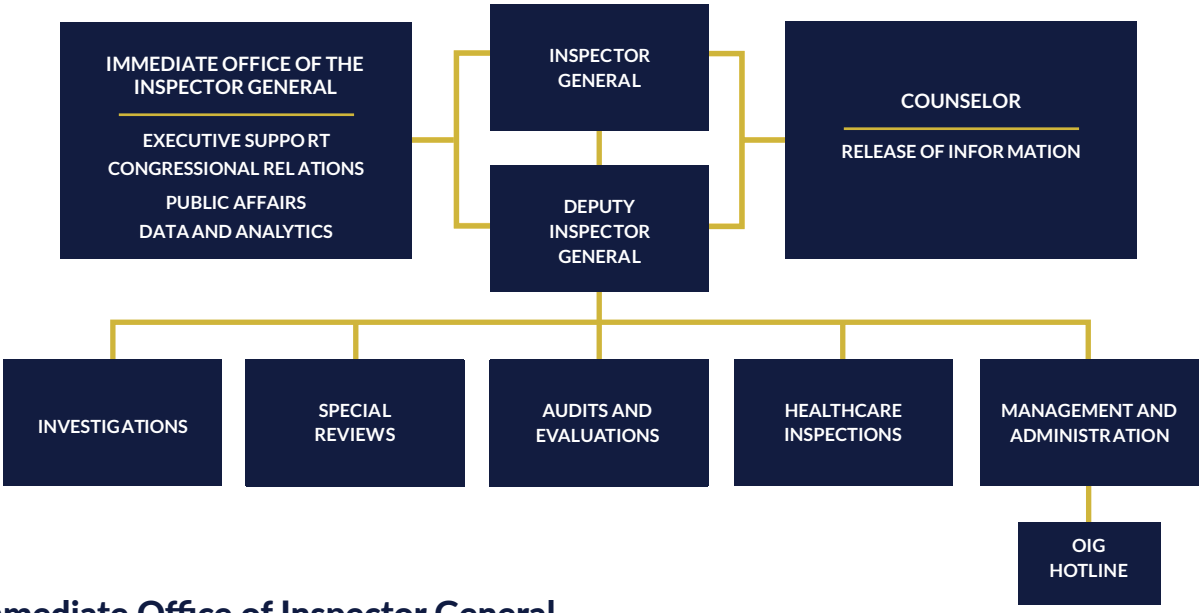
Under the law, as amended, the Inspector General is responsible for

- conducting and supervising audits and investigations;
- exercising full law enforcement authority;
- recommending policies designed to promote economy and efficiency in the administration of—and to prevent and detect criminal activity, waste, abuse, and mismanagement in—VA programs and operations; and
- keeping the Secretary and Congress fully and currently informed about problems and deficiencies in VA programs and operations and the need for corrective action.

In addition, Public Law 100-322, Veterans' Benefits and Services Act of 1988, charged the OIG with oversight of the quality of VA health care.

Organizational Overview

The OIG is headquartered in Washington, DC, and has more than 40 field offices throughout the country employing approximately 1,100 staff.



The Immediate Office of Inspector General

The inspector general and deputy inspector general provide leadership and set strategic direction for independent oversight of the second-largest department in the federal government. The office includes congressional and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed. The office also has a data and analytics group that specializes in information integration and data visualization. In addition, through report follow-up, the office helps to ensure that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

The Office of Counselor to the Inspector General

The Counselor's office provides legal advice to OIG leaders and is involved in all aspects of office operations. OIG attorneys provide legal support for investigations, audits, and inspections; work with criminal investigators in developing qui tam and False Claims Act matters; represent the OIG in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. The Counselor's office also includes staff who direct employee relations, reasonable accommodations, and the release of OIG information.

The Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters including health care, procurement, benefits, construction, and other

fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The office is staffed by special agents with full law enforcement authority, forensic auditors, and other specialized staff in regional field offices that use data analytics, computer forensics, covert operations, and other investigative techniques to detect and address conduct that poses a threat to or has harmed VA personnel, operations, and the veterans or other beneficiaries they serve.

The Office of Special Reviews

Special Reviews personnel conduct administrative investigations and other reviews of significance involving suspected misconduct or gross mismanagement affecting the public integrity of senior VA officials or programs, and other emergent issues of concern not squarely within the scope of another single OIG office. The office provides the OIG with the capacity and flexibility to respond to high-profile or exigent matters—often involving complex issues relating to multiple program offices and authorities.

The Office of Audits and Evaluations

Staff oversee VA's activities to improve the integrity of its programs and operations. The Office of Audits and Evaluations has four principal divisions that conduct audits and reviews focusing on (1) health care; (2) benefits; (3) financial management and information technology; and (4) acquisitions, contracting, and construction. The office also has groups performing functions such as quality assurance, strategic planning, statistical analysis, report production, and hotline referral review.

The Office of Healthcare Inspections

This office assesses VA's efforts to maintain a healthcare program that promotes high-quality patient care and safety and minimizes adverse events. Staff, primarily medical professionals, conduct rapid reviews and clinical evaluations of care prompted by OIG hotline complaints, congressional requests, and other leads. The office conducts focused inspections of individual medical facilities and systems through cyclical Comprehensive Healthcare Inspection Program site visits (both in-person and virtual when warranted) focusing on leadership, quality management, and adherence to standards for patient care. The Office of Healthcare Inspections also conducts reviews of VA care provided at its own medical facilities and through contracted community care providers, statistically supported national and behavioral health reviews, cyclical reviews of vet centers, and consultations for criminal investigators and audit staff as needed.

The Office of Management and Administration

Office of Management and Administration staff provide comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, and information technology services to the organization. Staff also manage emergency preparedness, training, external agency reporting, and records. In addition, the office oversees the OIG hotline, which receives, screens, and refers all allegations and complaints for additional action. Hotline analysts triage referrals—prioritizing those having the most potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress.

For more information, please visit the OIG home page at www.va.gov/oig.

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Other Resources

Semiannual Report

https://www.va.gov/oig/publications/semiannual-reports.asp

VA's Major Management Challenges

https://www.va.gov/oig/disclosures/management-challenges.asp

www.va.gov/oig

To report suspected criminal activity, waste, abuse, gross mismanagement, and safety issues to the OIG, contact the hotline:

Online: www.va.gov/oig/hotline

Mail: VA Inspector General Hotline (53H)
810 Vermont Avenue, NW
Washington, DC 20420

Telephone: (800) 488-8244

Fax: (202) 495-5861