



U.S. DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STRATEGIC PLAN 2018–2022 UPDATE
(February 28, 2021)



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

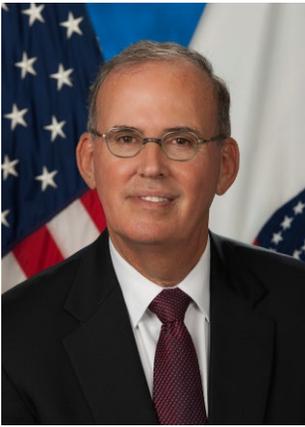
To perform audits, inspections, investigations, and reviews that improve the efficiency, effectiveness, and integrity of the Department of Veterans Affairs' programs and services.

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, equity, and inclusion 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



As we pass the one-year mark of our nation's response to COVID-19, I am issuing this update to the US Department of Veterans Affairs (VA) Office of Inspector General (OIG) *Strategic Plan for 2018–2022*. Our goals and objectives have not changed even as we have been navigating the pandemic. We continue to promote the efficiency, effectiveness, and integrity of VA's programs and operations. Our commitment to strategies that deter and address criminal activity, waste, and abuse while promoting improvements throughout VA is unwavering. However, the pandemic has caused significant challenges and shifting demands on both VA's work and our oversight efforts that are likely to be felt for years to come. We have had to adapt our approaches to comply with restrictions for on-site inspections and to ensure that oversight does not interfere with the critical support VA is providing veterans, their families, caregivers, and in some cases their communities. Implementing our strategic plan through 2022 must take these demands into account even as the OIG's foundational work continues to help ensure veterans receive the benefits and care to which they are entitled.

The OIG has designed this plan to be flexible and creative in responding to new threats posed by counterfeit personal protective equipment for front-line VA personnel; other pandemic-related fraud; barriers to vaccine and medical supply distribution; additional pressure on stressed VA systems; and the staggering demands for prompt access to quality care not only for COVID-19 patients, but for all those with other physical and mental healthcare needs. The OIG also continues to examine key factors that can make the difference between success and failure for other large priority initiatives, including the implementation of new systems for electronic health records, supply chain management, and financial management.

We honor our commitment to veterans by ensuring that our work remains independent, transparent, objective, fair, and impactful. We are dedicated to working with new and established leaders within VA, Congress, veterans service organizations, and other stakeholders affected by our work to help address the difficult challenges facing VA in the years ahead.

A handwritten signature in black ink, appearing to read "Michael J. Missal". The signature is fluid and cursive, with a large, stylized "M" and "J".

MICHAEL J. MISSAL
Inspector General

Strategic Goals

The OIG's following five strategic goals remain responsive to areas of need identified by VA, external agencies and organizations, the veteran community, other stakeholders, and OIG personnel. They reflect the OIG's steadfast commitment to veterans, their families, and the public, and to support the VA leaders and staff who serve them.

- 1. Healthcare Services.** Improve veterans' 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.
- 2. Benefits for Veterans.** Help ensure that veterans and their families receive benefits in a timely manner, and superior services for which they are eligible, by making recommendations to advance expeditious and accurate VA decision-making and processes for delivering benefits.
- 3. Stewardship of Taxpayer Dollars.** Identify procedures and strategies for making the most responsible use of VA-appropriated funds, including sound and closely monitored pandemic-related spending and procurement practices, and implementing financial systems that reduce the risk of fraud, waste, and misuse of resources.
- 4. Leadership and Governance.** Address emergent, pervasive, and persistent problems within VA that have arisen or gone unaddressed because of failures in leadership, including lack of accountability, poor governance, staffing deficits, and misconduct by individuals in positions of trust.
- 5. Information Systems and Innovation.** Assess and recommend enhancements to VA's infrastructure systems, including information technology, data security, and financial management that support VA operations. Through findings and report recommendations, highlight practices that promote quality standards that can be implemented throughout VA, particularly those that effectively use program planning, budget forecasting, and other predictive tools.

These goals will be advanced through VA OIG audits, inspections, reviews, and investigations that have the greatest impact on veterans' lives, investments of taxpayer dollars, and the public interest.

Top Strategic Objectives

Goal 1. Healthcare Services

- Promote access to healthcare providers who are qualified to address veterans' often distinct physical and behavioral health needs in a timely manner
- Oversee the quality of care provided by VA and its community providers

Goal 2. Benefits for Veterans

- Recommend improvements in decision-making and accountability at every stage in the benefits process—from eligibility determinations through delivery and appeals
- Advance the quality and delivery of VA services such as transitional assistance, home loans, training/education, and fiduciary and caregiver support

Goal 3. Stewardship of Taxpayer Dollars

- Identify savings and monetary recoveries by scrutinizing VA's financial management and controls, high-risk programs, and process efficiencies
- Focus criminal and administrative investigations on holding employees, contractors, and others accessing VA resources accountable for illegal or unethical conduct

Goal 4. Leadership and Governance

- Establish the root causes—and who is accountable—for identified problems including leadership vacancies, failures to meet ethical standards, and lack of policies or guidance
- Examine governance structures to determine if reporting lines and information-sharing mechanisms are effective and encourage efficient VA operations and program implementation

Goal 5. Information Systems and Innovation

- Review current and proposed financial, health record, inventory, and other electronic systems for their effectiveness in achieving VA's pandemic response and other goals, controlling costs, meeting user needs, and ensuring information is used, shared, and secured in a lawful and ethical manner
- Examine VA planning efforts on high-risk initiatives, and encourage the use of innovative approaches
- Recommend improvements to VA's organizational supports, policies, and guidance to advance programs and operations and remedy problems observed in multiple sites
- 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

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 40,000 contacts each year through its hotline alone. Concerns related to the impact of COVID-19 responses on programs, operations, and potential crimes 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 other stakeholders, and OIG groundwork all contribute to a vast pool of potential projects. In addressing fraud, waste, abuse, inefficiencies, and lack of effectiveness, the OIG employs approaches that result in saving and recovering taxpayer dollars whenever possible, as well as recommending improvements to VA programs and operations.

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 personnel are trained to conduct their work consistent with the highest quality standards and with objectivity, independence, and respect for the efforts of VA personnel on the front lines of service delivery to veterans.

The following are strategies that OIG staff are using to ensure that oversight efforts are successful and have a noteworthy positive effect.

Strategies for Achieving Goals and Objectives

Make recommendations to address root causes of identified problems

The OIG issues findings and recommendations that are based on available evidence, information gained from fieldwork (when safe and appropriate) and interviews, and an increased use of data analytics, virtual visits, and research. OIG work that identifies areas of concern or wrongdoing also examines who is responsible, failures in oversight, and the underlying causes of new and persistent problems.

Improve collaborations that yield 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, current, and practical.

**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 impact, nature, and scope of OIG work that will advance its 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 by OIG staff through fieldwork or trends detected by its hotline, data analysis and modeling, investigations, or other internal groups
- High-risk areas reported by GAO or other oversight groups (internal and external to VA), as well as areas of interest identified by Congress or the veteran community
- 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 successful 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 or privacy provisions. 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.

Outcome Measures

In assessing the successful implementation of the OIG’s strategic goals and objectives, the following are among the quantitative measures that are used, consistent with previously reported performance measures:

- Percentage of reports—audit, inspection, evaluation, contract review, and Comprehensive Healthcare Inspection Program 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 also provides as a resource on its public website a dashboard with report recommendations and their status as implemented/not implemented and additional information in its *Semiannual Reports to Congress*.)
- Monetary benefits (dollars in millions) from audits, investigations, contract reviews, inspections, and other evaluations
- Return on investment (monetary benefits divided by cost of operations in dollars)
- Percentage of recommended recoveries achieved resulting from postaward contract reviews
- Percentage of investigations 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 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 noted, as are changes in VA systems, policies, or practices resulting in part from OIG recommendations.

All measures help inform ongoing changes to the strategic plan, which is continually reviewed and adjusted to meet evolving needs.

Challenges and Risks to OIG's Strategic Plan

Consistent with the provisions of the Government Performance and Results Act of 1993, the OIG identified in its initial strategic plan potential internal complications and challenges “external to the [OIG] and beyond its control” that could affect the OIG fully realizing its strategic goals. These risks included internal issues such as the ability to quickly recruit and hire and then retain qualified staff with expertise in particular subject areas. Challenges experienced since the plan was first released have included hiring and onboarding staff in a largely remote work environment and shifting to virtual supervision and collaboration. Teams have been tasked to take on COVID-19-related work in addition to other program and operations oversight.

External challenges have included addressing rapidly changing VA guidance and tools that generate implementation concerns or complaints. OIG staff are also limited by pandemic restrictions from conducting on-site inspections and reviews. Staff and resources need to be realigned to provide timely information to VA to shape fast-paced pandemic responses. Even with the promise of widespread vaccinations and an eventual return to pre-pandemic operations, challenges continue in addressing both urgent and pending matters. Limitations with VA systems that the OIG needs to access for vital information can be a significant impediment. Examples include VA deficiencies in implementing supply chain, health record, and financial management systems. The level of engagement of VA leaders and vacancies in key positions also continues to shape OIG efforts. Finally, the OIG is limited by its lack of subpoena power to compel testimony from former VA employees and others outside the government.

The OIG remains flexible in order to remain responsive to veterans, Congress, VA personnel, and others who identify exigent or emerging issues. Both internal and external challenges require the OIG to balance COVID-19-related work with more long-term oversight of matters that pose the greatest risks to VA and veterans.

OIG History and Statutory Authority

In October 1978, the Inspector General Act of 1978 (Public Law 95-452) was enacted, establishing 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 more than 1,000 staff. In addition to the Immediate Office of Inspector General, the OIG is organized into the following offices:

- Audits and Evaluations
- Counselor to the Inspector General
- Healthcare Inspections
- Investigations
- Management and Administration
- Special Reviews

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 agency in the federal government. The office includes congressional and media 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 modeling 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 Audits and Evaluations

This office oversees VA's activities to improve the integrity of its programs and operations. OAE 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 of personnel performing functions such as quality assurance, strategic planning, statistical analysis, report production, and hotline referral review.

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 oversees the work of the Release of Information Office.

The Office of Healthcare Inspections

Healthcare Inspections assesses VA's efforts to maintain a healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct rapid reviews and other actions prompted by OIG hotline complaints, congressional requests, and other leads. The office conducts focused inspections of individual medical facilities and systems. Staff also conduct cyclical Comprehensive Healthcare Inspection Program site visits (which have been virtual while pandemic restrictions are in place) focusing on leadership, quality management, and adherence to standards for patient care. This office also conducts reviews of Vet Centers and the care at community-based outpatient clinics, statistically supported national and behavioral health reviews, and provides consultations to criminal investigators and audit staff as needed.

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 Management and Administration

Staff of the Office of Management and Administration 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 provide data analysis services and manage emergency preparedness, training, external agency reporting, and records. The office also 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.

The Office of Special Reviews

The Office of Special Reviews conducts 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.

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

For more information about the OIG, visit the website:

www.va.gov/oig

Follow the OIG on Twitter:

[@VetAffairsOIG](https://twitter.com/VetAffairsOIG)

**To report suspected criminal activity, waste, abuse, 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

